A study identifying factors affecting retention of midwives in Malawi

A dissertation submitted to the University of Liverpool, Liverpool School of Tropical Medicine, International Health Division, in partial fulfilment of the requirements for the award of the Master of Community Health (MCommH) degree

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EXECUTIVE SUMMARY

Introduction

One of the Millennium Development Goals (MDG) is to improve maternal health. Progress towards this goal is monitored in part by the coverage of skilled attendance at birth. The World Health Organization (WHO) defines a skilled attendant as a midwife, nurse or doctor with midwifery skills. There is a global shortage of midwives and this is a challenge for achieving the MDG on maternal health. Poor retention of midwives has contributed to a shortfall in skilled attendants at birth. This is the case in Malawi, a low income country, badly affected by the HIV/AIDS epidemic in sub-Saharan Africa. Here, health services are provided by the Ministry of Health and Population (MOHP), the Christian Health Association of Malawi (CHAM), the private-for-profit health sector and others. Health staff is concentrated in the urban areas while the population is largely rural.

The client for this study was the Safe Motherhood Project (SMP) in southern Malawi, whose aim is to lower the maternal mortality rate. One of the main barriers for the project to achieve its aim has been attrition of skilled attendants, such as midwives. Against this backdrop, SMP initiated this study on retention of midwives.

Aim
To identify factors affecting retention of midwives in Malawi

Objectives

1. To describe the size of the retention problem among midwives, including their major employment and non-employment destinations

2. To identify push and pull factors in midwifery as perceived by midwives and managers in the health sector, i.e. MOHP, CHAM and private-for-profit health facilities

3. To provide recommendations on improving midwifery retention

Design and methods

The first objective was achieved by reviewing secondary data, i.e. published and unpublished literature and by extracting descriptive statistics from an existing database over Malawian midwives.

The second objective was achieved through qualitative research methods such as focus group discussions (FGDs), in-depth interviews and one observation session. Participants in the four FGDs were midwives from the public sector and CHAM. One midwife from the private sector was interviewed. Seven in-depth interviews were conducted with key informants, such as managers, from the public and private-for-profit health sector, MOHP and non-governmental organisations (NGOs). The one observation session took place in an urban maternity ward. Participants were

recruited purposefully[1] from the twelve districts in Southern Malawi. Some key informants were recruited in the capital in central Malawi. All data collection was done in English by the researcher. She was assisted by a trained Malawian counterpart for the FGDs. Confidentiality was discussed and written and/or oral informed consent was sought from the participants prior to data collection. Flexible topic guides were used and took the form of open-ended questions followed by probing. Notes were taken by hand and/or with tape recorder and transcription was begun within 24 hours. Data was analysed using Ritchie and Spencer's framework and took place concurrently with data collection. Themes were identified and categorised as push and/or pull factors and the data were presented using the push-pull framework. Push factors were defined as factors pushing the midwife out of the public health sector, and pull factors were factors attracting her to stay in the public health sector. The quality of the methods and the data was assured by paying attention to the criteria for trustworthiness of qualitative research. Ethical approval of the research was granted by the Research Ethics Committee of the Liverpool School of Tropical Medicine and the Kamuzu College of Nursing, Malawi.

Findings and discussion

The study found that about half of the deliveries in Malawi are not assisted by a skilled attendant and thus Malawi is not on target in achieving the Millennium Development Goal on maternal health[2]. There are various ways of measuring the poor retention of midwives and these ways have inherent ambiguities. However, regardless of how the poor retention is measured and what the ambiguities might be, it seems that there is a severe and long standing problem with retaining midwives. Therefore, close monitoring of the retention problem is advisable, and the Malawi Nursing and Midwifery Council's (MNMC) database and exit interviews were found useful for doing so.

The research found that the two main forms of losses are that the midwives die or they go abroad. The latter is a loss not only in quantity but also in quality as it is the more experienced midwives who emigrate.

Possible ways of mitigating the loss through emigration could be to continue current efforts in enforcing codes of practice on international recruitment in recipient countries. This could go hand in hand with continued efforts in making the public health sector more attractive to the midwives.

A way of mitigating the attrition of midwives to death, largely due to HIV/AIDS, could be to provide free anti-retrovirals (ARVs) to those midwives who need them. The study found little literature on the likely impact of free ARVs on retention. Moreover, the study itself did not generate trustworthy findings on the issue. The reason for this was that the research method used (i.e. FGDs) was inappropriate to explore such a sensitive topic, and a more appropriate method (i.e. in-depth interviews with midwives living with HIV/AIDS) was not possible within this study. Therefore the likely impact of free ARVs on retention of midwives in Malawi remains unknown. Eventual further research on the topic might consider in-depth interviews with midwives living with HIV/AIDS.

[1] I.e. they were selected according to their relevance for the study.
[2] The target is that eighty percent of births should be assisted by a skilled attendant in 2005

The study identified inadequate remuneration as the main push factor and the midwives who did stay were found to use multiple coping strategies to supplement their income. On the one hand these coping strategies enable them to stay in the public sector. On the other hand, these coping strategies often have negative consequences on the quality of care due to the opportunity costs. The reviewed literature suggested that strategies used by the employer to retain the midwives are not likely to have significant and sustainable impact on retention if these strategies do not address the issue of inadequate remuneration.

Poor working conditions, lack of career structure and lack of job satisfaction were also found to contribute to poor retention.

Against the backdrop of multiple strong push factors, the study found four pull factors which attract the midwives to stay in the MOHP; namely the retirement package, access to post-basic training[3], a flexible leave policy and job security. Gender norms were found to be underlying reasons for the two latter pull factors, in the sense that a flexible leave policy enabled this largely female work force to combine work-related and domestic responsibilities. The job security meant that most of the midwives were guaranteed a job in an MOHP health facility when they moved in order to follow their husbands.

During data collection, two themes emerged. Firstly, the midwives expressed a wish to see a stronger Association of Malawian Midwives (AMAMI). The reviewed literature suggest that a well functioning and well established union can improve communication between the midwives and their employer, the MOHP, which in turn can enhance a joint approach to addressing the retention problem. Secondly, there seems to be an understanding among several stakeholders that the shortage of midwives would be solved if basic training of midwives[4] was resumed. This is not supported by the reviewed literature which emphasised the importance of also "sealing the leak" i.e. addressing the retention problem before investing in expansion of training.

Recommendations

The following recommendations are based on the study findings, supported by the reviewed literature and refined according to feedback from stakeholders in Malawi. A set of options for how retention of Malawian midwives could be improved is available in the dissertation, and only three prioritised recommendations are mentioned in this summary. It is hoped that the recommendations will be useful to the task force which was formed following the second presentation meeting and whose purpose is to look at ways of increasing skilled attendance in Malawi.

Inadequate remuneration was found to be the single most important reason why midwives left. Moreover, the reviewed literature suggested that if there is an issue of inadequate remuneration and this issue is not addressed, then other efforts to retain staff are not likely to have significant and sustainable impact. Therefore it is recommended that:

[3] i.e. training after having graduated as a midwife
[4] i.e. training to become a midwife

- The task force could facilitate the identification of a realistic level for the remuneration package to retain midwives. This increment could be costed by the MOHP and/or the upcoming Health Service Commission, and discussed with the Ministry of Finance and/or donors under SWAps or Budget Support. However, there may be risks involved with the sustainability of donor funding of remuneration, and also risks with implications for remuneration of other staff in the public sector.

The following recommendations are a priority because they suggest ways of mitigating the main forms of losses, namely attrition to migration and to HIV/AIDS.

- DFID and development agencies of other countries that employ Malawian midwives could continue advocating enforcement of codes of practice on international recruitment in their home countries.

- The above recommendation could go hand in hand with the MOHP to consider ways of making the public health sector in Malawi more attractive for midwives.

- There is a need for further research on the impact of free ARVs on retention of midwives. This research could benefit from conducting in-depth interviews with midwives living with HIV/AIDS. Experiences could be drawn from MSF-Luxembourg in Thyolo District, Malawi, and from some of the mining companies in South Africa.

ACKNOWLEDGEMENTS

I would like to extend my gratitude to the following people:

Kingsley Lungu, Esther Ratsma and Hannah Ashwood-Smith with Safe Motherhood Project for supervision in Malawi, as well as Tim Martineau, Liverpool School of Tropical Medicine for tutoring in the UK. I am indebted to Grenna Kaiya for research assistance, and to Anne Gordon for proof-reading.

I would like to thank the Department for International Development (DFID) in Malawi for housing one of the meetings at which the findings of the study were presented. Thanks also to the following participants at this presentation meeting for feed back on the preliminary recommendations: Sam Chembe, Ministry of Health and Population. Silicy Mgawi, Malawian Nursing and Midwifery Council. Chris Chaponda, Kamuzu College of Nursing. W. Gbomba, World Health Organization. Virginia Kamouo, Care International. Teresa Ingham, USAID. Solomon Chen, Medical Mission of Republic of China. And from DFID: Richard Cibulskis, Jackie Peace, Christopher Phiri and Susan Mshana.

I am grateful to Don Osborne, Catherine Mundy, Clarissa and Richard Stevenson for accommodation in Blantyre, Lilongwe and Liverpool, respectively. Thanks to Miriam Chilongo, Joyce Makawa, Aaron Phiri and Margreet Heemskerk for friendship, and to Paul Mackintosh, my partner, for encouragement and support.

My acknowledgements to the following foundations in Denmark for financial support towards my studies: Prins Joachim og Prinsesse Alexandras Internationale Uddannelsesfond. Knud Wiedemann og hustru Rigmor Wiedemann, født Vogts, familielegat. Fabriksejer, civilingeniør Louis Dreyer Myhrwold og hustru Janne Myhrwolds Fond. Torben og Alice Frimodts Fond. Frimodt-Heineke Fonden. Grete Bording-Legatet.

Last, but not least, thanks to the key informants for interviews and for sharing published and unpublished documents. I am grateful to the women in labour who accepted to participate in this research by letting me observe in the maternity ward. And to the midwives for sharing their thoughts and concerns with me:

> *"Now we have said all our concerns and maybe after a year we can see a change. Not that we should say that Lene and Grenna have taken our concerns and we have no feed back"*
> Midwife in focus group discussion

I hope this dissertation contributes to putting retention of midwives high on the agenda in Malawi.

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LIST OF ABBREVIATIONS

AIDS:	Acquired immunodeficiency syndrome
AMAMI:	Association of Malawian midwives
ARV:	Anti-retroviral drug
CHAM:	Christian Health Association of Malawi
CHV:	Community health worker
DFID:	Department for International Development (UK)
DOH:	Department of health (UK)
FGD:	Focus group discussion
HIV:	Human Immunodeficiency virus
ICM:	International Council of Midwives
ICN:	International Council of Nursing
IHA:	Independent health care association (UK)
ILO:	International Labour Office
LSTM:	Liverpool School of Tropical Medicine
MDG:	Millennium Development Goal
MDHS:	Malawi Demographic and Health Survey
MCommH:	Masters in Community Health (LSTM)
MIM:	Malawi Institute of Management
MMR:	Maternal mortality rate
MNMC:	Malawi Nursing and Midwifery Council
MOHP:	Ministry of Health and Population (Malawi)
MSF:	Médecins Sans Frontières
NGO:	Non-governmental organisation
NHS:	National Health Service (UK)
PEP:	Post-exposure prophylaxis
RCN:	Royal College of Nursing (UK)
RNHA:	Registered nursing home association (UK)
SMP:	Safe Motherhood Project
SWAps:	Sector wide approaches
TBA:	Traditional birth attendant
TOR:	Terms of reference
USAID:	United States Agency for International Development
VOICES:	Voluntary organisations involved in caring for the elderly (UK)
WHO:	World Health Organization

CHAPTER ONE - INTRODUCTION

1.1 Millennium Development Goals and global shortage of midwives

In year 2000, all member states of the United Nations adopted the Millennium Declaration which aims at reducing poverty as well as promoting health, education and the environment. The Declaration is to be implemented by achieving a set of ambitious goals by 2015, known as the Millennium Development Goals (MDGs) (1). Africa is not on target with regards to achieving the MDGs in the time planned (2).

One of the eight goals is to improve maternal health. In order to monitor progress towards this goal, two indicators have been developed, namely, the maternal mortality rate (MMR) and the proportion of deliveries assisted by a skilled attendant[5]. More specifically, the second indicator states that by 2005, eighty percent of births should be assisted by a skilled attendant. By 2010, this should be increased to eighty-five percent. And ultimately in 2015, maternal deaths should be reduced by three-quarters by ensuring that ninety percent of all births are delivered by a skilled attendant (1).

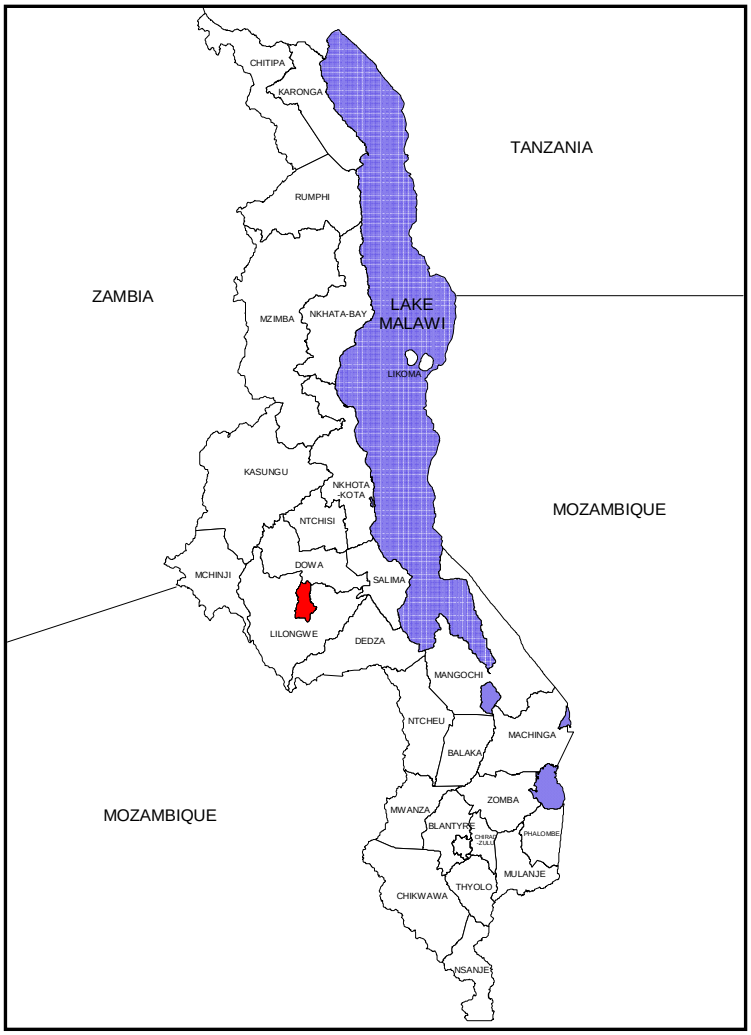
This is a challenge since there is increasing global concern over growing shortages of midwives, who are the main providers of skilled attendance at birth. Both industrialised and developing countries are affected but to different extents (3), and within countries there is often a significantly larger problem with retention of midwives in the rural areas than in the urban areas. In many settings in sub-Saharan Africa, the low retention has contributed to creating a full blown human resources crisis (4).

1.2 Malawi

Malawi is a small country in Southern Africa (see figure 1 below). It had a population of 9.93 million at the last census in 1998, and this figure is expected to increase to 14.4 million in 2007. About three-quarter of the inhabitants live in the rural areas, and it is thus still a largely rural society (5). Poverty reduction is at the top of the political agenda in a country with one of the lowest per capita income rates in Africa (6). The widespread poverty is reflected in the poor health indicators (7): Life expectancy at birth has fallen to 39 years mainly due to malaria and HIV/AIDS. The latter is now the leading cause of death in the most productive age group (20-48 years) and the estimated national prevalence of HIV/AIDS is 8.8%. As in other settings, the HIV/AIDS infection rate among young women is significantly higher than among men of the same age group (7). Also in other aspects of life, the gender dimension is pronounced, with women having less access to education, resources and formal employment (7).

[5] Skilled birth attendants are defined by the World Health Organization (WHO) as trained midwives, nurses, nurse/midwives or doctors. Traditional birth attendants, including those who have been trained, are not defined by the WHO as skilled attendants (2)

Figure 1: Map of Malawi (8)



1.3 Malawi health sector

There is a variety of health service providers in Malawi: The Ministry of Health and Population (MOHP) accounts for 40% of the formal health facilities, followed by the semi-autonomous Christian Health Association of Malawi (CHAM) which provides somewhere between 20% and 43% of the services[6](7,9). There is a small private-for-profit health sector limited to the urban areas, including hospitals with maternity wards (10). One-woman-run, private midwifery clinics are very few, in total there are six licensed clinics nationwide (11,12). There is a vast number of national and international non-governmental organisations (NGOs) active in health. The scale of the traditional health sector is unknown; however, it is estimated that a quarter of all deliveries are assisted by traditional birth attendants (TBAs) (7). Primary health care is provided at a village level by rural health centres/clinics. At a district level, secondary level health care is given in district and CHAM hospitals. Many districts have both. In the two major cities, Lilongwe and Blantyre, there

[6] Different sources give different figures

are referral hospitals which provide tertiary level of care, as well as primary and secondary level health care for inhabitants in the city (10).

There is an inequitable distribution of health workers, in the sense that while the majority of the Malawians live in the rural areas, the health workers are concentrated in the urban health facilities[7]: For example, ninety-seven percent of the clinical officers employed by the MOHP are urban-based, while eighty-two percent of the government-employed nurses[8] are in the urban areas (10). However, a larger proportion of the enrolled nurse-midwives are to be found in the rural areas namely twenty-two percent, than the registered nurse-midwives where less than five percent work in the rural areas (10). Thus it can be argued that the backbone in maternal health in rural Malawi is made up of enrolled nurse-midwives rather than registered nurse-midwives. Contrary to the MOHP staff, the vast majority of CHAM facilities, and thus CHAM staff is to be found in the rural areas (10).

1.4 Safe Motherhood Project in the Malawi health sector

The client for this study was the Safe Motherhood Project (SMP) which is part of the National Safe Motherhood Programme in Malawi (13). The latter was established by the Malawi Government in an attempt to lower the high MMR which was estimated to be 620 maternal deaths per 100,000 live births according to the 1992 Malawi Demographic and Health Survey (MDHS), and doubled to 1120 deaths per 100,000 live births according to the year 2000 MDHS (14).

SMP had a total budget of nine million pounds sterling and is still running from 1998 up to the end of 2003, when it will be integrated into the MOHP. The strategy was to strengthen all MOHP and CHAM health facilities which are involved in maternal health in southern Malawi. This was done via a comprehensive package of health education, rehabilitation, supplies of drugs, equipment and ambulances, training of staff in midwifery skills etc. (13). Participatory needs assessments were done in all 12 districts which SMP covers, and all project activities were based on these findings.

The SMP's six-monthly reports over the years reflect an increasing awareness of the human resources crisis, and the voice is ever more desperate (15). However, midwife recruitment and retention is beyond the control of the SMP. Presently, as the project comes to an end, there seems to be a general feeling that the shortage of health staff in general and midwives in particular, has been a major constraint for the project's ability to have the expected impact on the MMR: It is even said that the shortage of skilled attendants has been the "killer assumption" for the project (16).

The SMP therefore asked the researcher to conduct a study analysing why midwives leave the job in Malawi, to supplement existing studies on the issue (see Terms of Reference (TOR) in annex 1). It is hoped that the findings of this study will be useful for policy makers, donors and other stakeholders. A small task force of these stakeholders has been set up after the presentation meeting at the office of the Department for International Development (DFID) in Lilongwe in September 2003. The aim of the taskforce is to come up with clear recommendations for how the shortage of skilled attendants can be overcome.

[7] Urban is here defined as a health facility (either hospital or health centre) located at district or central level (10)

[8] This includes all types of nurses. Nurses in Malawi can broadly be divided into two main categories: The registered nurses who have received a more comprehensive training than the enrolled nurses. Most of the registered nurses have been trained in midwifery. Almost all enrolled nurses have received some midwifery training. In this study, the terms "nurse-midwives" or simply "midwives" refer to both registered and enrolled nurses unless stated otherwise.

1.5 Summary of the introduction

The poor retention of midwives has contributed to a global shortage and is a challenge for the achievement of the MDG on improving maternal health. This is true also for Malawi which is a low income country, badly affected by the HIV/AIDS epidemic in sub-Saharan Africa. Here, the main providers of care are MOHP and CHAM. Health staff is concentrated in the urban areas while the population is largely rural. In the rural areas, the main providers of skilled attendance at birth are enrolled nurse-midwives. The client for the study was SMP who aims at lowering maternal deaths, but the shortage of skilled attendants has been a “killer assumption” to the project. A small task force has been set up in Malawi to increase the coverage of skilled attendants.

CHAPTER TWO - LITERATURE REVIEW

2.1 Introduction

This chapter falls into three main parts: First, the author will describe the main approaches in the literature to understand retention. The theories of Herzberg and Maslow will be presented as they are useful for understanding the role of pay in retaining staff. Second, the researcher will explain the push-pull framework which is often used to analyse retention. Critics from the literature on this framework will be presented. Third, the author will describe ways of assessing the retention problem and give examples from the literature of strategies to retain staff. Then, follows a brief summary of the literature review.

2.2 Main approaches to understanding retention of staff

In the literature, there are two main approaches to understanding retention: Economic and holistic (17). From an **economic** point of view, the health labour market is determined by money, and health workers[9] will be attracted to, and retained by, the employer who offers the best deal, i.e. the best remuneration (18). The economic approach does not explain why many midwives are retained in their job in the public health sector while there are better paid jobs available to them elsewhere: Either in the private health sector, with NGOs or abroad. This suggests that there are other factors than economics which influence the dynamics of the midwife workforce (17).

The **holistic** view is that the midwife's decision on where to work or whether to work at all, is influenced by economics, but also by a range of other factors originating from the social, cultural and political context she lives in. Gender relations are especially important here (17). A recent study among female health workers in Pakistan found that if their work was organised in a way which better enabled them to combine work-related and domestic responsibilities, then they were more likely to stay in the job (19).Studies with a holistic approach also take the health workers' commitment to the profession into consideration. In two recent studies from the industrialised world (20,21) "vocation" or the wish to "make a difference" was found to be reasons for midwives to choose to go into the profession. A health facility manager in South Africa expressed this as:

> *"…we have a service to deliver, we have people looking up towards us for help, hope and for survival and you have to be committed, you have to have responsibilities to be able to push forward in this profession"*
> (22) page1

In conclusion, the holistic approach seems useful in understanding Malawian midwives, who are a largely female work force in health.

[9] "Health workers" is used as a collective term for all cadres in the health sector throughout the dissertation.

2.2.1 The role of pay in a holistic approach

The holistic approach acknowledges that pay has a role in retaining staff. The question is then to what extent pay determines the employee's decision to stay or leave the job. Herzberg's two-factor theory and Maslow's hierarchy of needs are useful in answering that question.

Herzberg's theory is based on findings from a study on job satisfaction in the USA. What Herzberg found is that there are two distinct sets of factors which impact on the way people feel about their job: One set being the so-called "dis-satisfiers", and the other set named "satisfiers" (23). The "dis-satisfiers" are the factors which are related to the context of the job, e.g. salary and working conditions. The "satisfiers" are factors which are linked to the content of the job such as achievement, appreciation/recognition, promotion/advancement etc (24). In order to make the employee feel neutral about the job and perform at an average level it is essential that the "dis-satisfiers" are met. That is to say that the basics such as salary, working conditions etc. are perceived as fair by the employee. If the employee perceives her salary and working conditions as unfair (i.e. the "dis-satisfiers" are not met) then it is not likely that appreciation and promotion (i.e. "satisfiers") will make her feel satisfied, and she may eventually resign (25). The key thing in Herzberg's theory in relation to this study is that recognition, advancement, a sense of achievement etc. cannot make up for inadequate salary and working conditions, except maybe in the short term.

According to **Maslow's needs hierarchy** (26) human beings have five major categories of needs (see annex 2): Firstly, the physiological needs, e.g. oxygen, food, water. Secondly, the need for safety. Third are the social needs for love and acceptance as belonging to a group. The fourth category has to do with esteem in the sense of having respect from others and of oneself, i.e. self-esteem. Finally, there is self-fulfilment which is the need to develop and apply one's potential and skills (26). These five needs are organised in a pyramid to reflect that there is a hierarchy among the needs: Once a lower need has been satisfied, then the individual can start focusing on a higher need. Notably, the needs for self-fulfilment and esteem are rarely dominant if the individual is pre-occupied striving to fulfil the basic physiological, safety and social needs[10] (26).

Herzberg's two-factor theory is in line with Maslow's needs hierarchy (26) (see annex 3) in the sense that Herzberg's concept of "dis-satisfiers" largely equals Maslow's basic physiological, safety and social needs. Likewise, Herzberg's "satisfiers" are comparable to Maslow's needs for esteem and self-fulfilment.

This review identified few studies conducted in a low income setting on retention of health staff. Those found, showed that poor pay is a major reason for resigning. Dovlo states that *"salary levels are probably the most basic factor in retention"* (27 page 6), and he bases this on case studies from countries such as Botswana and Ghana. In Uganda, increased salaries for physicians have improved retention and even encouraged returning to the job (28). In a recent large study on international nurse mobility initiated by the WHO, the gap between pay levels in the developing and the industrialised countries was found to be the main factor for nurses to migrate. Other factors such as opportunities for post-basic education and career were less important (29).

[10] Maslow's needs hierarchy is criticised for not being evidence-based and for being too rigid in classifying needs hierarchically (26). However, it is beyond the scope of this review to summarise this debate which has been ongoing for five decades.

Based on the theories of Herzberg and Maslow and on the above mentioned studies, the author concludes that strategies to retain midwives in the job which appeal to the midwives' higher needs/ "satisfiers" while failing to meet the basic needs/"dis-satisfiers" are not likely to have a significant and sustainable impact on retention.

2.3 The push-pull framework

The author did not find a solid and comprehensive framework to analyse retention of health workers in a developing country. Researchers in human resources in health confirmed that there is no such framework (9,30). The push-pull framework is widely used (3,17,20,29,31,32) in current studies on retention and migration of health workers and will be described in the following.

The push-pull framework is known from a variety of contexts, ranking from customer surveys (17) in the private sector to research in the nineteenth-century emigration from Europe to the Americas (33). The framework "[compares] *the origin and destination in terms of their overall combination of push factors (repulsions) and pull factors (attractions)"* (17 page 64). In other words, the health worker is likely to leave the job if she perceives that the combination of push factors from the origin and pull factors from the destination makes leaving a favourable option (17).

2.3.1 Common push factors

Retention and migration studies typically mention the factors listed below in no significant order, as push factors out of the health sector.

An **unfair remuneration package** is a common push factor (3,20,21,27,28,29) The remuneration package is defined as all monetary rewards that the employee gets in return for her contribution to the organisation, i.e. basic salary, allowances, pension etc. (34). It is the employee's perception of whether her remuneration package is fair or unfair which is important in her decision to stay or to leave, rather than how her remuneration package compares to a cost of living index (34) "[An adequate remuneration package is] *essential but rarely achieved as health worker salaries are generally bound by fairly rigid public service guidelines"* (35 page 4)

Delayed payment of the remuneration package is another push factor (4). This can be for several months (4) and is often a result of inefficiently administered payrolls (28): *"Centralized minor administrative procedures involve various government departments and poor information technology can make simple processes a frustrating experience"* (28 page 7)

Most retention studies list **poor working conditions** as a push factor (3,20,21,27,28,29)). Herzberg defines working conditions as *"the physical conditions of work, the amount of work or the facilities available for doing the work"* (24 page 48). Since Herzberg developed his theory in 1959, there has been increasing awareness of work related stress (23,34) provoked by "*stressors* [such as] *high work loads, requirements for working fast and meeting strict deadlines, conflicting demands and interruption. Problems are seen to arise when exposure to such demands is chronic and elicits a strong enough pattern of responses to strain the individual's physical and mental resources*" (36 page 518). A stressor specific for health workers, is the possibility of litigation: *"Everything had to*

be somebody's fault… it can't just happen… it has to be someone to blame. And it did make you very wary" British midwife (21 page 22)

Career structures are defined as follows:

> *"Career structures have a two-fold purpose: they provide the organization with a mechanism to produce sufficient staff with the necessary levels of skills and experience to undertake the higher level functions in the organization as posts fall vacant; and they allow individuals to satisfy their need for progress, improvement and achievement"*
> (37) page 351

Lack of career structure is common in developing countries (35) and this is a push factor out of the public health sector (29).

Remote, rural positions in the public health sector are perceived as unattractive (38) and they are thus a push factor. This is even more so for a female work force:

> *"Socio-cultural factors often preclude women from accepting positions in rural, remote areas for extended periods of time. In addition, in countries that impose rural compulsory service as a requirement for graduation and professional certification, women may not be able to graduate or exercise their professions"*
> (32) page 12

Another push factor is **lack of job satisfaction** (19,20,21,27) Herzberg found that "satisfiers", such as a sense of achievement and recognition, should be met in order for the employee to feel satisfied with the job (24). A pharmacist in South Africa has put is as: *"If you are right, there is silence – no recognition. If you are wrong – you hear from everyone"* (22 page 2).

Exposure to HIV/AIDS in the work place is a push factor, especially from obstetrics and surgery. This is against a backdrop of health systems stretching to cope with the combination of increased case load and increased attrition of staff, both largely due to the HIV/AIDS epidemic (39)

> *"Increasing levels of illness, absenteeism and death are to be expected among health workers in high-prevalence countries, threatening the ability of health systems to provide care. HIV transmission through needle-stick injuries within the hospital is a small, but real, risk, and a significant worry for many staff. Limited data suggest that staff recruitment is being adversely affected and that self-deployment away from perceived risky activities such as obstetrics and surgery is already taking place*"
> (39) page 61

2.3.2 Common pull factors

In the following, the author will list the typical pull factors. These were defined slightly differently in different studies; in some research, pull factors were factors which attract the health worker to the destination (3,27,28,29). In other studies, the factors which pull the health worker to stay in her place of origin were considered pull factors (20,21). The latter definition is used in this review and

also consistently throughout the dissertation. In other words, pull factors are here factors which attract the midwife to stay in the public health sector.

The **retirement package**, i.e. end of service payments of various kinds is a pull factor. This is illustrated in the cases of Namibia and Lesotho. The two countries remunerate health workers similarly except in terms of the retirement packages: Namibia offers a more attractive retirement package and also has better retention of staff (28). However, studies suggest that generous retirement packages are not enough to make young and middle-aged staff stay in a job that they are otherwise dissatisfied with. The retirement package is mainly a pull factor for the older employees (34).

A study among Pakistani female health workers found that "*flexibility in time use, particularly in relation to the taking of leave for family commitments and emergencies… could reduce the drop out rate"* (19 page 268). In a study among British midwives, it was found that "*midwives who left midwifery because of their 'family commitments' are more likely to consider returning than midwives who left for other reasons"*(21 page 100). In other words, if the interconnectedness of female health workers' private and professional lives is acknowledged, and if this results in **flexible leave policies**, then that is a strong pull factor to stay in or even return to the job (34).

In a recent study among public health workers in the UK it was found that **job security** attracted people to the sector (20).

Accessing **post-basic training**[11] is another pull factor (3,21,27) There might be more reasons for this. First, training and professional development is a way of meeting the need for esteem and self-fulfilment as described by Maslow (26) Thus an employee who can develop and apply her potential and skills is more likely to stay in the job. Second, "*training, especially overseas training, is a highly priced opportunity to increase one's market value to complementary employers and to migrate to cities or even internationally"* (40 page 582). In other words, post-basic training is a two-edged sword: On the one hand, the future opportunity to go for post-basic training is a pull factor to stay in a job. On the other hand, once the employee has finished post-basic training, then she is more likely to leave the public sector, and thus post-basic training becomes a push factor. The double-faced nature of post-basic training as a pull and a push factor is a complex issue. Suffice to say for this review that there is evidence in the literature that post-basic training as a push factor can, to various extents, be counterbalanced with adequate and well-imbedded retention strategies targeting the trained employee (34). Moreover, developing the employee is a good investment for the employer who can benefit from a more competent staff member in the future (41)

2.3.3 Critics of the push-pull framework

There are critics saying that the push-pull framework simplifies the complex structures of the real world:

> *"Quite clearly, individuals migrate for a number of different causes… Nothing is easier than to compile a list of 'push' and 'pull' factors and present them as a theory*

[11] i.e. further training after having graduated as a midwife. Not to be confused with basic training, i.e. training to become a midwife.

> *of migration. The customary survey reporting percentages endorsing each such 'cause' might be useful as a sort of first approximation to the question of who migrates. In no way, however, does it explain the structural factors leading to patterned movement, of known size and direction, over an extensive period of time"* (42)

Bogue adds to this argument by saying that:

> *"Any citing of just push and pull factors is now* [1969] *generally considered as being far too simplistic to explain observed migrations. We can recognise the presence of both push and pull factors in both origin and destination. In addition, attention must also be paid in particular to 'intervening obstacles' that can impede particular migrations, such as family obligations at the origin, the costs of moving, legal constraints and personal anxiety about migration…"* (43)

Both Portes and Bogue advocate a holistic approach to understanding migration and argue that the push-pull framework is not holistic. However, at present three decades later, retention and migration literature does not offer an alternative to the push-pull framework, i.e. a solid and comprehensive framework to analyse retention of health workers in developing countries. Most current studies use the push-pull framework, but fail to discuss the advantages and disadvantages of this framework. This is also true for a recent, large-scale study funded by the World Health Organization (WHO), the International Council of Nurses (ICN) and the Royal College of Nursing (RCN) (29). As a consequence, this retention study with Malawian midwives is left to use the push-pull framework.

2.4 Retention of staff

The employer can influence how the employee perceives the combination of push factors out of the job and pull factors to stay in the job, and thereby increase the likelihood that the employee is retained in the job. However, the scope for improving retention of staff has often been neglected and rather have efforts been put into increasing the production of staff:

> *"Expanding training capacity* [i.e. basic training to become a midwife, and not post-basic training as was touched on above]*… has often been the main and immediate response to…* [shortage of staff]. *Expanding production without sealing the leak cannot be an efficient response"* (27) page 7

There is a strong case for "sealing the leak", i.e. address the retention problem, in a time of staff shortages (34).

2.4.1 Assessing the size and nature of the retention problem

Before addressing a retention problem, it is necessary to assess the size and the nature of the problem. The size and trends of the shortage of staff can be assessed via descriptive statistics, while qualitative data can tell about the nature of the problem.

Descriptive statistics are a broad collective term for various indicators. A few of them will be further explained below, such as skilled attendance at birth, vacancy rates, staffing levels and "critical point".

Coverage of **skilled attendance at birth** is a useful statistic for assessing the shortage of midwives, besides being an indicator of progress towards the MDG on maternal health. A skilled birth attendant has been defined as:

> *"exclusively … people with midwifery skills (for example doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications"* (44)

As earlier mentioned, Traditional Birth Attendants (TBAs) including those who have been trained are not considered skilled attendants by the WHO.

Skilled attendants include other cadres than midwives. A more specific measure for midwife shortages is the **vacancy rate** among midwives, i.e. the number of unfilled posts out of the total number of established posts[12], expressed in percents. Vacancy rates should be taken with a pinch of salt:

> *"What bench mark levels will indicate a problem? Ten percent-vacancy or twenty percent-vacancy? Are established staffing levels adequate or too high/too low? These indicators will need to be further investigated"* (28) page 22

Both "skilled attendance at birth" and vacancy rates are conventionally given as nationwide figures. Other measures of staffing levels such as the **number of midwives per health centre** are more indicative of eventual rural/urban mal-distribution.

A study on retention of pharmacists in Ghana found that the pharmacists typically left the public health sector two to three years after graduation: This was the **"critical point"** in time where the risk of the employee leaving was greatest. Further investigation revealed that two-three years work experience from the public sector was what it took to open a private pharmacy. (9). In other words, it was identified *when* the loss of staff appears (the "critical point") by descriptive statistics, and then qualitative methods were used to understand *why* the loss happens at that time.

Another kind of qualitative data which can tell about the nature of the problem are **exit interviews** (23,34). These are interviews with leavers about their reasons for resigning. The purpose is to

[12] Or against other yard stick such as ability to carry out health service plans, work load, professional opinion etc. (45) This study will use the yard stick "established posts" as this is the one used by MOHP Malawi in their vacancy analysis.

provide the employer with an overview of push-pull factors in the organisation and allow for comparison between units, cadres and over time (34)

2.4.2 Retention strategies

Once the size and nature of the retention problem has been assessed, adequate retention strategies can be chosen. This section will present retention strategies on job satisfaction, representative bodies, greener pastures, free anti-retrovirals, coping strategies.

In Thailand, **job satisfaction** for rural doctors was improved by introducing public recognition awards such as the "best rural doctor of the year prize" (46). Another cheap, feasible and easy-to-manage initiative was launched in Indonesia and contributed to improving job satisfaction among female community health volunteers (CHVs) (47): A baseline survey found that the CHVs were not satisfied with their volunteer work, they did not feel appreciated and many had left. Therefore, radio spots were launched with stories such as a village elder telling a CHV that he appreciates her efforts, or a mother telling another mother how a CHV saved her child. A follow-up survey three months later found that the radio spots had improved the CHVs' job satisfaction and retention. (47)

A guideline to evaluating human resources in the health sector (45) mentions the need for "*managing labour relations and finding ways for effective involvement and communications between employers and staff and including their representing bodies* [i.e. unions and professional associations]*"* (45 page 26) At the same time, it is well-known that poor communication between employer and employees can cause dissatisfaction, poor retention and occasionally strikes (34). In some countries, the roles of the representing body and the regulating body are muddled (45). A representative body is meant to act as representative for its members and defend their legal rights. In contrast, the purpose of a regulating body is to set the principles, guidelines or targets for the health work force, often on behalf of the state (45). Based on the above, the author concludes that a retention strategy can be to strengthen a **representative body** and thereby improve communication between employer and employees. It must be ensured, however, that the roles of the representative body and the regulating body are clear to all stakeholders.

Emigration for **greener pastures** is a factor contributing to loss of health staff in developing countries (27,28). Both source countries and recipient countries have put strategies in place to protect the health systems in developing countries (29). More specifically, these strategies have taken the form of codes of practice for ethical recruitment which embraces the public and/or private health sector in recipient countries (see annex 4). In the source countries the following measures have been taken: Firstly, bonding of health workers after graduation. This has rarely been successful, mainly because compulsory service is difficult to enforce (27,28). Secondly, negotiating a fee as compensation from the departing health worker or the destination country. Finally, in the Caribbean attempts have been made to manage and moderate the loss to emigration in order to minimise damage to the home countries. This policy initiative is often referred to as "managed migration" (29).

Free anti-retrovirals (ARVs) are increasingly mentioned as a retention strategy of health staff (5,8) living with HIV/AIDS. However, there is very little existing knowledge on the impact of free ARVs on retention. The experience from a private company in South Africa is that the employees are reluctant to be tested due to stigma. Furthermore, the company does not provide free ARVs to

the spouse and family, and the employee usually cannot afford the drugs for his/her spouse in case s/he is infected too. This contributes to a low uptake of ARVs, and thus the impact of ARVs on retention of staff is not great (48). A pilot project by Médecins Sans Frontières (MSF) in Malawi found that initially staff was reluctant to accept free ARVs but now they are breaking the denial and coming forward for the drug (8,49).

Health workers use various **coping strategies** to make ends meet and thereby enable them to stay in the job despite an inadequate remuneration package:

> *"Health sector workers respond to inadequate salaries and working conditions by developing various individual 'coping strategies' – some, but not all, of which are of a predatory nature"*
> (40) page 1

Examples of coping strategies are: sale of drugs that are supposed to be free, under-the-counter fees, pressure on patients to attend private consultations, work on the side etc. It is argued that governments need to recognise these coping strategies and consider the underlying reasons for them, as well as assessing the positive and/or negative impact they have on health service provision. (40)

2.5 Summary of literature review

This literature review has found that a holistic approach is appropriate for understanding retention of Malawian midwives. Based on Herzberg's and Maslow's theories, it was concluded that strategies to retain midwives in the job, which appeal to the midwives' higher needs while failing to meet their basic needs, are not likely to have a significant impact. The push-pull framework was introduced, and push factors were defined as factors pushing the midwife out of the public health sector. Examples of these were unfair and delayed remuneration package, poor working conditions, lack of career structure, remote and rural positions, lack of job satisfaction and exposure to HIV/AIDS. Pull factors were defined as factors that attract the midwife to stay in the public health sector, and examples of these were the retirement package, flexible leave policies and job security. Post-basic training was found to be a pull factor, but also a push factor which could be mitigated. The push-pull framework did not reflect a holistic approach, but the researcher found no alternative. The employee's perception of push and pull factors was found to be susceptible to retention strategies. Descriptive statistics such as skilled attendance at birth, vacancy rates, number of midwives per health centre and "critical point(s)" were found useful to establish the size and trends of the retention problem. Exit interviews were a useful management tool to understand the nature of the retention problem. Retention strategies on job satisfaction, representative bodies and "greener pastures" were reviewed. Finally, the likely impact of free ARVs on retention and health workers' coping strategies were described.

. CHAPTER THREE - METHODS

3.1 Aim and objectives

Aim

To identify factors affecting retention of midwives in Malawi

Objectives

1. To describe the size of the retention problem among midwives including their major employment and non-employment destinations

2. To identify push and pull factors in midwifery as perceived by midwives and managers in the health sector, i.e. MOHP, CHAM and the private-for-profit health facilities

3. To provide recommendations on improving midwifery retention

3.2 Study design

The aim of the research was to identify factors affecting midwifery retention in Malawi. In other words, to find out what midwives and other stakeholders perceive as push and pull factors in midwifery in Malawi. A fundamental principle in qualitative research is that there are multiple realities and different people have different perceptions (53). Therefore qualitative research methods were chosen to achieve the purpose.

At the same time, staff shortages in the public sector are inevitably a political issue. Therefore there was a need to establish whether there really is a shortage of midwives and if so, the size and trends of the problem. Descriptive statistics from a national and district level were useful to achieve this first objective. Within the given time frame, it was not feasible to compile nationwide statistics on the coverage of skilled attendance, vacancy rates, staffing levels etc. Therefore the decision was made to extract these descriptive statistics from existing secondary sources such as: Registers with the MOHP, a database of Malawian midwives with the Malawian Nursing and Midwifery Council (MNMC), and published and unpublished literature.

3.3 Research setting

The research setting was Blantyre town, in the southern part of Malawi. This is the town where the client, SMP, has its office and the South is the area that it covers. Midwives from various places in the southern part of Malawi had come for clinical training in Blantyre and data collection with them took place in the locations where their training was conducted, namely the Grace Bandawe Conference Centre and the Kamuzu College of Nursing. Three trips were done to the Malawian capital, Lilongwe, in the central part of the country in order to collect data there.

3.4 Study population

Table 1: Study population

Characteristics	Justification
Midwives	
• Enrolled or registered nurse/midwives *and* • working in MOHP or CHAM or private-for-profit health sector	• midwives in MOHP are the focus of the study • midwives in other sectors to compare and contrast findings from public health sector
Key informants	
• managers in MOHP (district and central level) or CHAM or private-for-profit health sector • regulatory body, i.e. MNMC • union, i.e. AMAMI	• compare and contrast with midwives' perception • insight into why the current situation is as it is
Women in labour	
• women in labour during observation sessions in maternity ward *and* • having an uncomplicated delivery	• observation session of midwives in maternity ward inevitably involved observing women in labour and their newborns

The focus of the research was midwives working in the MOHP. Analysis of retention problems between different departments/sectors may shed light on causes for poor retention (34). Therefore, midwives employed by CHAM or the private-for-profit health sector were added to the study population.

Key informants are defined as people who are particularly knowledgeable and whose insight can help the researcher understand what is happening (53). Managers in the health sector and representatives from regulatory bodies and unions are likely to have a vast institutional memory and insight on the research question and were therefore identified as key informants. The managers and representatives from the regulatory body are likely to see things differently from the midwives and their perceptions can therefore serve as comparison to the midwives' perceptions.

Since the research included an observation session in a maternity ward, women in labour and their newborns[13] became part of the study population.

[13] No companions were allowed in the maternity ward observed and that is why they do not figure here

3.5 Recruitment of participants

Table 2: Participants

	Sector: MOHP	Sector: CHAM	Sector: private-for-profit	Sector not applicable	Total	Female	Male
Registered nurse/midwives	17	1	1[14]	0	19	16	3
Enrolled nurse/midwives	9	6	0	0	15	14	1
Managers	3	0	1	1[15]	5	3	2
AMAMI	0	0	0	1	1	1	0
MNMC	0	0	0	2	2	2	0
Women in labour	0	0	0	15	15	15	0
Total	29	7	2	19	**57**	51	6

Within the study population, participants for the research were recruited purposefully, i.e. according to their relevance for the study and no pre-determined sample size was aimed for (54,55). Rather was the aim to reach the saturation point (54), i.e. when no new themes come up during data collection.

The opportunity was taken to recruit midwives gathered for residential courses with SMP and the Kamuzu College of Nursing. In this way the research did not interfere with their professional or household tasks, neither was transport a constraint. The recruited midwives were further stratified into sub groups in order to triangulate data from different informants (54): i.e. one group of enrolled midwives, two of registered midwives and one mixed groups. Initially, the researcher wanted to recruit from the hard-to-reach group of midwives who have left midwifery via snowball sampling (55), i.e. asking the working midwives in the FGDs if they know of midwives who have left the job. This proved to be virtually impossible. However, many of the recruited midwives expressed intention to leave. Their perception of why midwives leave the job is used as a proxy for the reason why those who actually left, did so (56).The private-for-profit midwives were difficult to reach as they are few and not participating in the SMP training programme. However, one private-for-profit midwife was recruited via snowball sampling.

Key informants were sampled in consultation with SMP and via snowball sampling from other key informants and through the yellow pages. They were approached via e-mail or phone and meetings were then planned in their offices in Lilongwe or Blantyre, according to the wish of the informant.

Gaining access to a maternity ward was difficult and so the researcher took the opportunity to join the recruited midwives during their practical training in an urban, central maternity ward for the purpose of observation. Fifteen women in the ward who had normal deliveries and their newborns were recruited for the research. This urban health facility should ideally have been triangulated with a rural health centre. This was not feasible though (see limitations).

[14] The private-for-profit midwife was interviewed and did not participate in a FGD
[15] A manager in an NGO involved in maternal health

3.6 Methods used for data collection

Table 3: Methods

Methods	Justification
Objective 1	
• Review secondary data (i.e. published and unpublished literature plus MNMC database) in UK and in Malawi	• Contextualise primary data collected under objective 2 • Use available descriptive statistics on the size of the retention problem (57) • To find out current knowledge and reveal gaps or bias in current knowledge (57)
Objective 2	
• Focus group discussion with midwives	• Interaction of FGD can make a range of views explicit (54) and the objective is to reveal various perceptions of push and pull in midwifery • Facilitating FGDs was a learning opportunity for the researcher
• In-depth interview with key informants and on one occasion with a midwife	• Key-informants are rich in information • If not enough midwives for a FGD in a stratified sub-group
• Observation session in maternity wards	• Triangulate verbal data with visual data • For the researcher to 'get a feel' for the context
Objective 3	
• Discussion at presentation meetings with stake holders	• Group dynamic among stakeholders with different –and possibly opposite- views on the issue (54) in order to get feedback on the acceptability and feasibility of the recommendations[16] • Chairing presentation meetings was a learning opportunity for the researcher

[16] *"The people who will make use of the evaluation information should be closely involved in generating the recommendations. They are more likely to act on things that they have thought out for themselves than on ideas foisted on them by an outside evaluator. From your point of view, as an evaluator, they are a valuable resource enabling you to escape being over-influenced by your own prejudices"* (58) page 517.

There is a range of methods available to the qualitative researcher. The methods chosen with justifications are listed in table 3. A few additional comments are given in the following.

The two **presentation meetings**[17] are considered a step in the data collection. These meetings generated new data as the participants were explicitly asked in the invitation letter (see annex 5) to give feedback on the preliminary recommendations.

The researcher conducted four FGDs with a total of 33 midwives. Despite this number being only a fraction of the Malawian midwives, it was clearly felt that a saturation point had been reached. No new push and pull factors emerged and most often the new findings confirmed findings from previous FGDs. The four FGDs were composed as follows: the first FGD consisted of ten enrolled nurse/midwives, the second was made up of five registered nurse/midwives and there were nine registered nurse/midwives in the third group. Finally, there was a mixed group of nine midwives in the fourth group. Moreover, the researcher conducted eight in-depth interviews (one with two informants and one with a private-for-profit midwife) and one observation session.

[17] One in Blantyre and one in Lilongwe, which were convenient for the stakeholders

3.7 Process of data collection

Table 4: Data collection process *(for keys to the table please see following page)*

Activity	Who facilitated/ interviewed?	Where?	What language(s) were spoken?	When?	How long did it take?	Was a topic guide used?	Who were the participants?	was consent written?	Was consent oral?	Was confidentiality discussed?	Were participants paid in any way?	Were drinks offered ?	Who was recording?	Was the data recorded by hand?	Was the data recorded by tape?	Was transcription started within 24 hours?
FGD 1	P	GBC	E	PM	1 ¾ hours	Y	10 ENMs	Y	-	Y	N	Y	M	Y	Y	Y
FGD 2	P	GBC	E	PM	1 ½ hours	Y	5 RNMs	Y	-	Y	N	Y	M	Y	Y	Y
FGD 3	P	KCN	E	AM	1 hour	Y	9 RNMs	Y	-	Y	N	N	M	Y	Y	Y
FGD 4	P	GBC	E	PM	1 ½ hours	Y	5 ENMs & 4 RNMs	Y	-	Y	N	Y	M	Y	Y	Y
Inter-view 1	P	Off	E	AM	45 min	Y	Informant & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 2	P	Off	E	AM	45 min	Y	Informant & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 3	P	Off	E	PM	1 ½ hours	Y	Informant & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 4	P	Off	E	AM	2 ½ hours	Y	Informant & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 5	P	Off	E	PM	45 min	Y	Informant & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 6	P	Infor-mants' home	E	PM	1 ½ hours	Y	Informant & P	-	Y	Y	N	Y	P	Y	N	Y
Inter-view 7	P	Off	E	PM	1 ½ hours	Y	Informant & M & P	-	Y	Y	N	N	P	Y	N	Y
Inter-view 8	P	Off	E	AM	1 ½ hours	Y	Informants & P	-	Y	Y	N	N	P	Y	N	Y
Obser-vation session	P	Ward	E C	AM	3 hours	Y	Participants & P	-	Y	-	N	N	P	Y	N	Y
Presen-tation meeting 1 Blantyre	P	B-DHO	E	AM	1 ½ hours	-	Stakehol-ders & P	-	-	-	N	Y	P	Y	N	Y
Presen-tation meeting 2 Lilongwe	P	DFID	E	AM	2 hours	-	Stakehol-ders & M & P	-	-	-	N	Y	M	Y	N	Y

Keys to table 4:

AM: In the morning
B-DHO: Blantyre District Health Office
C: Chichewa
E: English
ENMs: Enrolled nurse/midwives
M: Malawian counterpart to the principal researcher
GBC: Grace Bandawe Centre where SMP holds their courses
KCN: Kamuzu College of Nursing
P: Principal researcher
N: No
Off: In the informant's office
PM: In the afternoon
RNMs: Registered nurse/midwives
Y: Yes

From table 4 it can be seen that all data were collected in English by the principal researcher while her Malawian counterpart recorded and transcribed the data. The Malawian counterpart is studying journalism and speaks and writes English very well, but it was nevertheless felt useful to ensure that she and the principal researcher had the same understanding of issues relevant for the research. Therefore **training of the Malawian counterpart** was done for a total of two days in the following areas, ethics, privacy and confidentiality, qualitative research. FGDs and communication (for details see annex 6).

Moreover, the table shows that **topic guides** were used for all FGDs, in-depth interviews and the observation session. Topic guides were tailor-made for each key informant. After each FGD, the topic guide was adapted to include new themes. The researcher's combined checklist and topic guide for FGDs is in annex 7. This is the one used for the last FGD and thus the most refined. The guide was flexible and was not followed point for point. Rather the discussion was allowed to flow freely and only at the end of the discussion would the researcher introduce topics from the list which had not come up previously (54). The topic guide reflects the push-pull approach chosen as framework for the study: open-ended questions and probing is used to reveal which factors make midwives stay in the public sector and which factors make midwives leave the job. During the observation session, the researcher also used a topic guide and looked for visual data associated to the factors identified in FGDs and in-depth interviews, e.g. workload, exposure to HIV/AIDS etc.

Before every FGD, **information and consent forms** (annex 8) were passed around, and after clarifying eventual questions, the participants were asked to sign. A few had clarifying questions but no one was reluctant to participate. Oral consent was taken from every key informant and no one declined to participate. It was the same in the maternity ward.

The search for **secondary data** was ongoing from April to October 2003. The strategy was:

- Electronic sources:
  Web pages of: UN organisations, World Bank, WHO, DFID, Afro-Nets, ILO, International Council of Midwives (ICM), International Council of Nurses (ICN), Royal College of Nursing

(RCN), National Health Services (NHS) and others. The search words were “retention”, “human resources”, “midwife”, “midwives”, “qualitative research” and “Malawi”

- Databases: University of Liverpool’s database, Pubmed, Medline, Cochrane and others.

- Hand search:
  Previous operations research reports with SMP
  Library of “Kadale Consultants” in Blantyre, Malawi
  Daily national newspapers in Malawi throughout the period

- Researchers/key informants in the field:
  Researchers and consultants in human resources in health were contacted in the UK, Canada and Malawi for published and unpublished documents.

The first objective of the study was to be achieved with descriptive statistics and the author searched for information on: skilled attendance, vacancy rates, staffing levels, the relative importance of the different reasons for leaving midwifery, rural-urban distribution of health staff, the “critical point” (as explained in the literature review) for leaving midwifery. These descriptive statistics were all collected from secondary sources e.g. the database of Malawian midwives with MNMC and nationwide statistics from the MOHP. Publications from Malawi Institute of Management (MIM) and various NGOs were also obtained. The researcher could not access policy papers on salary scales nor district level staffing returns, as both were considered too sensitive to share with an external researcher.

3.8 Data analysis

The researcher used the framework developed by Ritchie and Spencer (59) to analyse her qualitative data from FGDs, in-depth interviews and the observation session. Data analysis took place concurrently with data collection (54). In other words, the researcher started analysing the transcribed tapes and the typed-up notes within twenty-four hours. Familiarisation with the data started with transcribing. By reading transcripts several times, a range of key themes emerged. These were then categorised under two headings, namely, “push factors” or “pull factors” following the dichotomy of the study design and the topic guide. Moreover, the study design aimed at comparing findings between midwives in MOHP and midwives in CHAM and the private-for-profit sector. This design was adhered to in the analysis as MOHP-midwives’ view on each theme, for example, workload, was compared with quotes from CHAM or private-for-profit-sector midwives’ perception of their workload. In the same way, findings from managers/employers were contrasted with findings from the midwives/employees. The last step in the Ritchie and Spencer framework is interpretation. A preliminary interpretation of the data was done before leaving Malawi and this served as the basis for the preliminary recommendations presented to the stakeholders. On return in the UK, further interpretation was done during a presentation session with colleagues in the MCommH class: the researcher asked for feedback on a surprising/controversial finding.

No software was used to analyse the qualitative data as the amount of data was easily manageable without such tools. “Word” and “Excel” were used to make basic graphs and tables based on the collected descriptive statistics.

3.9 Quality assurance

The quality in qualitative research depends on the trustworthiness of the research methods and the findings. Trustworthiness is a collective term for the following four concepts (54): firstly, credibility, i.e. whether the findings are credible, secondly, transferability, i.e. whether the reader has been provided enough information to judge if the findings are applicable to other contexts and groups, thirdly, dependability, i.e. would the findings repeat themselves if the data collection was redone with the same or alike participants in the same or alike context. Finally, confirmability i.e. that the participants and the setting have determined the findings rather than being influenced by the researcher (60)

In this study **credibility** was enhanced by doing member checks (60): At the end of FGDs the researcher summarized points raised (see topic guide in annex 7) and ensured that they were perceived in the same way by both researcher and participants. Key informants were invited for the presentation meetings to give their feedback on the research findings and recommendations.

Transferability of the findings was increased by explicitly describing methods used and the process of analysis (60). Moreover, all quotes on a controversial finding relating to HIV/AIDS have been annexed to this dissertation in order to increase transparency in the research.

In an attempt to ensure **dependability,** triangulation was used when designing the study (53,54,60). This is to say that findings were compared and contrasted from different methods (review of secondary data, FGDs, in-depth interviews, observation session, presentation meetings) and different sources (midwives in various sectors and key informants).

Confirmability refers to the procedure whereby an independent third party reviews the research (60). This was not done systematically, but the research methods and findings were discussed occasionally with colleagues from the MCommH, who were also conducting qualitative research but who were outsiders to this study's context and research question.

Both the principal researcher and her Malawian counterpart were trained in qualitative research methods, and this contributed to the quality assurance of the study. The principal researcher had followed a short course in qualitative research at the Liverpool School of Tropical Medicine (LSTM) and her Malawian counterpart was trained for a total of two days. For details on this training, please see annex 6. The Malawian counterpart was recruited prior to the author's arrival in Malawi. The recruitment was successfully done by an experienced qualitative researcher in SMP.

3.10 Ethical considerations

The following measures were taken to ensure that the research was ethical. Approval was granted by the LSTM Research Ethics Committee (see annex 9). In Malawi, ethical approval was given by the Dean of Postgraduate Studies and Research at the Kamuzu College of Nursing, permitting a FGD with postgraduate nursing students in the college (see annex 10). Prior to applying to LSTM Ethics Committee, the researcher was discouraged from doing in-depth interviews with Malawian midwives living with HIV/AIDS. The researcher conformed to this limitation.
Participants were asked for informed written or oral consent prior to data collection. None of the women in labour expressed distress by the researchers' presence. If so, the researcher would have

withdrawn immediately. Midwives were the focus of this study and there was thus a risk that data collection would interfere with service delivery. This was avoided as FGDs took place at residential courses. Neither did the FGDs disturb the training, since they all took place outside scheduled classes. Time and place for FGDs and in-depth interviews was done according to the wishes of the informants and a private and confidential place was located on all occasions.

CHAPTER FOUR - FINDINGS

4.1 Introduction

In the first half of this section, the author will present findings relating to objective one, i.e. statistics describing the size of the retention problem and the midwives' major employment and non-employment destinations.

In the second half, the author will present results relating to the second objective, i.e. push and pull factors as perceived by midwives and managers in the public, private-for-profit and CHAM health sector.

4.2 Findings relating to objective one

4.2.1 Coverage of skilled attendance

Coverage of skilled attendance[18] at birth is an indicator of progress towards the MDG on maternal health (62). Poor retention of skilled attendants contributes to poor coverage. Therefore, the proportion of births assisted by a skilled attendant reflects the size of the retention problem among midwives, who are the main providers of skilled attendance at birth.

The most recent figure on skilled attendance in Malawi is from year 2000 (14). By then, about half (56%) of deliveries were assisted by a skilled birth attendant. However, there was an inequitable coverage, in the far north and scarcely populated district, Karonga the figure was only 45%, while 81% of deliveries had skilled attendance in Blantyre district. This district is located in the densely populated southern part of Malawi and houses the commercial capital, Blantyre.

In conclusion, the skilled attendant coverage indicates that there is a large problem with retention of midwives in Malawi.

4.2.2 Vacancy rates among midwives

Vacancy rates tell how many of the established posts are unfilled. Thus they indicate the shortage of staff relative to the desired number of staff, and in this way vacancy rates point to the size of the retention problem.

Vacancy rates among MOHP staff disaggregated in cadres were available for the following years 1992, 1996, 1998 (63). Vacancy rates among midwives were found for year 2002 (10) but it was not

[18] Skilled birth attendants are defined by the WHO as s trained midwives, nurses, nurse/midwives or doctors. Traditional Birth Attendants, including those who have been trained, are not defined by the WHO as skilled attendants (61)

feasible to disaggregate them into MOHP staff and CHAM staff and thus they were not comparable to the vacancy rates from the previous years. Therefore they are not included here.

Table 5: Vacancy analysis for MOHP personnel by cadre (63)

Year	Cadre[19]	Established posts	Filled posts	Vacancy	Vacancy rate
1992	Registered nurse	736	499	237	32%
	public health nurse	35	20	15	43%
	Enrolled nurse/midwife	1308	1017	291	22%
1996[20]	Registered nurse	662	422	240	36%
	Enrolled nurse/midwife	1343	962	381	28%
1998	Registered nurse	717	379	338	47%
	public health nurse	17	10	7	41%
	Enrolled nurse/midwife	1549	1264	285	18%

Table 5 shows that the best scenario is that "only" about one in five posts is unfilled (enrolled nurse/midwife 1998, 18%). The worst scenario is that about half of the posts are vacant (registered nurse 1998, 47%)

The vacancy rate for registered nurses has increased significantly from 1992 to 1998, namely from 32% to 47%. This has happened despite a decrease in established posts. In 1992 there were 736 posts, but this was lowered to 717 posts in 1998. The vacancy rate for enrolled nurse/midwives has been largely stable (22% in 1992 compared to 18% in 1998). This is despite establishing more posts over the period (1308 posts in 1992 and 1549 posts in 1998). The vacancy rate among enrolled nurse/midwives is consistently lower than among registered nurse/midwives.

The public health nurses are disregarded in this narrative as they are few in number and thus have little impact on the national coverage of skilled attendance.

In conclusion, there is a big discrepancy between the desired number of midwives and the number of employed midwives in the MOHP. This gap seems to be bigger among registered nurse/midwives than among enrolled nurse/midwives. It is a long-standing problem. Throughout the 1990s the vacancy rates are generally speaking increasing, or at the best stable.

[19] Until 2001 all nurses (registered, public health and enrolled) were trained as midwives as part of their basic nurse training programme (64) This is to say that even though midwives as a cadre do not figure in the tables, all registered, public health and enrolled nurses in the tables can be considered skilled attendants.

[20] For unknown reasons, vacancy rates for public health nurse positions are not given for the year 1996 in source (63).

4.2.3 Number of midwives per health centre

Vacancy rates are one way of looking at staffing levels. However, they reveal little about the number of staff per health centre. Annex 11 shows that fifteen districts average fewer than 1.5 nurse/midwife per health centre. Moreover, five districts have less than one nurse/midwife per health centre (65).

4.2.4 "Critical point"

As described in the literature review, the critical point(s) indicate one or more moments in a midwife's life or career where statistics show that there is an increased risk of her leaving the job.
In order to establish eventual critical point(s) among Malawian midwives, the researcher gained access to MNMC's database which includes all Malawian nurse/midwives, whether registered or enrolled. The full database has 6969 names, but only 839 are recorded with age and this information is essential for defining critical point(s). Therefore a sub group of the 839 nurse/midwives were extracted. These fall into the following categories used by MNMC and therefore also in this study:

- Absconded: Left the job without notice and reasons why they left are unknown.
- Unknown: Known to have completed basic training to become a midwife but nothing is known of their whereabouts or what has happened to them.
- Deceased: Left midwifery because they died
- Retired: Left because they retired
- In training: Left for post-basic training
- Overseas: Left to go to another country in the region or outside the region
- Office: Left for office work related to midwifery
- Changed career: Left for another profession
- Practising: Still practising

The biggest category was "practising" with 571 midwives in it. The two main reasons for leaving were "deceased" (81 midwives) and "overseas" (48 midwives). These three categories total 700 midwives (i.e. 571 plus 81 plus 48).

A "cut-off point" by age was then decided on: i.e. only midwives in the productive age (20 to 65 years old) were considered in the following analysis. This left the researcher with 668 midwives. Based on the 668 midwives, a bar chart was made which shows the age distribution of the midwives in these three categories[21] (see annex 12).

The chart in annex 12 shows that more than half of the deaths (58%) occurred before the age of 45 years. At the same time, it is known that in countries with an adult HIV prevalence of just below 10%, such as Malawi[22], almost 80% of all deaths among 25-45 years old are associated with HIV/AIDS (63).

The chart further illustrates that it is the most experienced midwives who leave. About two in three (63%) of the emigrating midwives are between 35 and 50 years of age.

[21] For leavers, the age recorded in the bar chart in annex 12 is the age they were when they left midwifery. For practising midwives, the age recorded in the chart is their current age, i.e. in 2003.
[22] As mentioned in the introduction, Malawi has a national prevalence of HIV/AIDS at 8.8% (2002 data) (7)

4.2.5 Relative importance of leavers' destinations

The second half of the first objective for this research was to describe the major employment and non-employment destinations for leavers. In other words, where do the leavers go? This applies not only in terms of geographical moves, but also moves into post-basic training, retirement etc.

The researcher found that the MNMC database would be useful to achieve this. At the same time, it was not important to know the age of the leavers for the destination-analysis. Therefore the researcher wanted to access the MNMC data base a second time in order to base the destination-analysis on a bigger part of the MNMC data base. This was not feasible (see limitations) and therefore the destination-analysis was done based on the initial group of midwives extracted for the analysis of the critical point(s), the so called "critical point group".

The practising midwives were taken out of the critical-point-group as they have, obviously, not left midwifery. Then only the leavers were left, i.e. the midwives who had "absconded" or were "unknown", "deceased", "retired", "in training", "overseas", "office", "changed career". They totalled (839 minus 571) 268 people and made up the group for the destination-analysis. The relative importance of the destinations of the leaving midwives is shown in figure 2 below.

Figure 2: Relative importance of leavers' destinations (source: MNMC's database, n = 268)

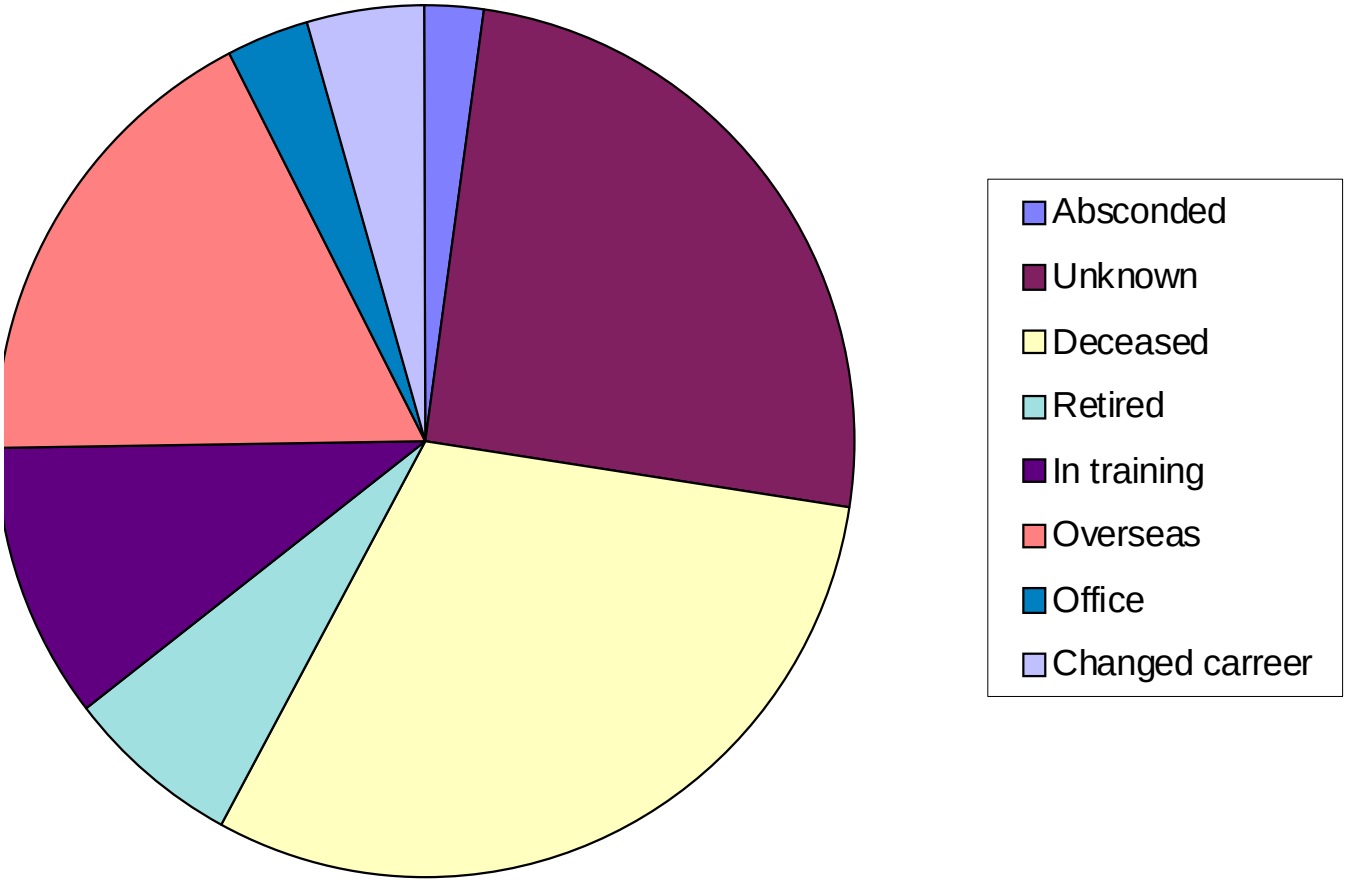


Figure 2 shows what has already been mentioned above, namely that the two main reasons why Malawian nurse/midwives leave the profession are to die or to go abroad.

4.2.6 Summary of findings relating to objective one

Based on descriptive, secondary data it was found that: first, the retention problem among Malawian midwives is important as indicated by the following findings. About half of the deliveries are not assisted by a skilled attendant. The vacancy rates in midwifery are high (from 18% to 47%) and it is not uncommon to have one nurse/midwife run a health centre. Second, the two main "destinations" or forms of losses for Malawian nurse/midwives who leave the profession are dying or going abroad. The latter is a loss in terms of both quantity and quality as it is the experienced midwives who leave.

4.3 Findings relating to objective two

This section will present findings relating to the second objective of the study: i.e. push and pull factors as perceived by midwives and managers in the public, private-for-profit and CHAM health sector.

The focal point is the voice of midwives employed in the public health sector, but other voices are also brought in with the purpose of comparing and contrasting with the perceptions of the public sector midwives.

The findings will be presented with a focus on the narrative of the participants in focus group discussions and interviews. Findings from observation sessions will be added where relevant.

The lay out of this section is as follows. First, identified push factors to leave midwifery in the public health sector will be described under the headings "remuneration package", "greener pastures", "working conditions", "human resources functions", "job satisfaction" and "HIV/AIDS". Second, all pull factors found to make the midwives stay in the public sector will be listed under one heading, namely "pull factors". In the end, the author will briefly present findings on a new theme which arose during data collection. This will be done under the heading "AMAMI and MNMC". Finally, there will be a summary of the findings relating to the second objective.

4.3.1 Remuneration package

This section begins with describing the remuneration package, followed by quotes on how the midwives' perceive their remuneration. Finally, the coping strategies which the midwives use to make ends meet are explained.

Low salary was repeatedly, consistently and unanimously throughout the FGDs mentioned as the main factor pushing midwives out of the public health sector.

> *"People leave…because they are looking for better salaries. That is the main problem"* Public sector midwife in FGD 4

> *"The salary is not relevant compared to the pressure of work we do"*
> public sector midwife in FGD 2

> *"The salary of midwives does not compare to other civil servants with a similar number of years training such as teachers and police"*
> President of Association of Malawian Midwives in interview

> *"In all I have worked for about 25 years… With only my poor salary which is from hand to mouth I will retire a poor person and I'll become a popper*[23] *and yet they will say 'this was a registered nurse'. I will just have the title but I don't have anything. Things are very unfair and this is exactly what is happening"*
> public sector midwife in FGD 2

[23] The researcher was told that a "popper" is somebody who lives from selling popped corn in the market.

It was difficult to get a clear picture of exactly what the remuneration package includes and the size of the various components in it (see limitations of the study). In the absence of exact figures, the following quotes give an indication:

> *"On top of the basic salary there is professional allowance which is small and housing allowance which is acceptable and there is a medical allowance[24]. But they are pathetic"*
> Manager in the public sector in interview

However, the midwives disagreed that the **housing allowance** is acceptable:

> *"There is a house allowance which is 2500 kwacha[25] for some and 1500 kwacha for others. Still this is not enough because houses are now expensive"*
> public sector midwife in FGD 1

Included in the remuneration package is a **retirement package** which is paid as a one-off lump sum:

> "[the retirement package] *is about 135,000 kwacha after working for 20 years. But you will see retired nurse/midwives coming back because of the shortage of staff. For the retires ones it is* [on a] *monthly basis* [monthly renewed contracts]"
> public sector midwife in FGD 4

The midwives feel that they get an **inadequate remuneration**:

> *"It is really difficult to survive with our salary especially with our society whereby we depend on each other very much. Suppose I am the first born in the family that means I have to support the rest who come after me"*
> public sector midwife in FGD 3

> *"I cannot pay the tuition for my children in a good school which is about 10,000 kwacha and I only get 3,000 kwacha"*
> public sector midwife in FGD 1

Transport costs to come to work are high, and in some cases are reported to make up about one-third of the basic salary:

> *"My salary is 4,000 kwacha per month and I spend 60 kwacha per day on transport to come to work"* public sector midwife in FGD 3

> *"I'm still working hard and I have to walk going to work. This discourages me"*
> public sector midwife in FGD 4

[24] Medical allowance should not be confused with health insurance. The name of this allowance indicates that only employees with a comprehensive training in a medical profession, e.g. medical doctors and midwives, receive this allowance.
[25]Kwacha is the Malawian currency. The exchange rate was 108,3 Malawian kwacha to 1 US $ on October, 17 2003 (66)

In addition to the remuneration package being perceived as unfair, a few midwives were unhappy that the payment was sometimes delayed:

> *"In some cases we get salaries after three months. It is even worse when you are a beginner. You can stay for six months without getting your salary"*
> public sector midwife in FGD 4

One way of making ends meet was to attend post-basic training. In other words, it was one of the **coping strategies** used by the midwives:

> *"When there are workshops only the registered nurse/midwives are given opportunity to attend, and they are given allowances for those workshops and enrolled nurse/midwives are not given that opportunity"*
> enrolled nurse/midwife from the public sector in FGD 1

Or ask for emergency loans from the employer[26] to build a house:

> *"If you want to get a loan for a house, it takes years before they can actually give you that"*
> public sector midwife in FGD 2

The midwives also used other income generating activities to supplement their salary such as: rearing chickens for sale, selling imported goods in the market, selling home made freezes [27]and scones to patients, selling drugs from the pharmacy to the patients, and doing shifts in the private sector. The latter is limited to urban areas and currently small scale, however.

4.3.2 Greener pastures

This section will first explain what the Malawian midwives think of when they say "greener pastures". Then it will be described how these "pastures" form an internal hierarchy.

The term "greener pastures" was frequently used by the midwives and was explained to the researcher as a collective term for the following employment destinations:

- Abroad: United Kingdom, South Africa, Botswana, Far East, Middle East, USA, Libya.
- NGOs.
- Private health sector.
- CHAM
- Other professions e.g. secretary

[26] There may be a language and/or cultural difference here: A loan in British-English is money which is to be reimbursed to the lender. The researcher was explained that a loan in Malawian-English is more like a donation which may, or may not, be reimbursed.

[27] Freezes are frozen soft drinks, which are eaten like ice cream.

These destination forms a hierarchy of greener pastures in the sense that: The poorest remuneration package is the one in the public sector, according to the midwives' perception. The CHAM remuneration is perceived as slightly better than the public sector:

> *"Basically the salary is the same, but some conditions are good"*
> CHAM midwife in FGD 4

> *"In some mission hospitals they would arrange transport for nurses to go for shopping. In CHAM… there are free uniforms, free houses. You can get a loan, you can have a garden to plant your own food and you don't have to buy. All these small things make a difference..When a nurse gets sick she is taken care of in a separate room. In CHAM even if you only work for 2-5 years they will still give you something when leaving. Unlike the government where you need to work for 20 years first, then they can give you your package. Even if you work for 19 years and then leave, then they will not give you anything"*
> CHAM midwife in FGD 2

> *"It's better in the CHAM: If you start in the middle of the month, you get two weeks salary at the end of the month"*
> CHAM midwife in FGD 4

One up in the "hierarchy of greener pastures" in terms of monetary remuneration is the private-for-profit sector which, in the example studied, uses a comprehensive package of incentives to attract and retain staff. Anecdotal evidence suggests that the package has even made leavers return. The package consists of: basic salary, housing allowance, transport allowance, risk allowance, private health insurance for the employee and fifty-percent-subsidised fees for family members, life cover[28], night shift allowances, special-skills-allowance, on call allowance and a subsidised canteen for staff. In one case studied, an experienced midwife working in the private-for-profit sector would end up with approximately 19,000 kwacha per month in her hand. However:

> *"The private sector nurses are not satisfied either"*
> private-for-profit sector midwife in interview

The reasons for their dissatisfaction are other than monetary, as it will be described later.

Another step up the "hierarchy of greener pastures" is the non-governmental organisations which:

> *"poach staff from the private sector because they are funded with money from abroad and do not need to make profit"*
> private-for-profit manager in interview

Finally, the top of the hierarchy, money-wise, is to work abroad (within the region or in another continent).

[28] i.e. if an employee dies, her/his family is paid a lump sum equivalent to 3 years' salary.

4.3.3 Working conditions

This section will present what the midwives said about their workload, about the availability of equipment/supplies and about accountability towards users for mistakes.

The combination of low staffing levels and a high **workload** was epitomised as:

> *"If you have your tea break you know that at least one woman will deliver unattended"*
> public sector midwife during observation session in a maternity ward

Generally it was felt that the maternity wards were busier than other wards. The nurse/midwives explained that while in general wards most patients will only need attention occasionally, then in the maternity ward:

> *"it is not easy to conduct many deliveries at the same time for one nurse/midwife.. and usually there is only one midwife to do all the work in the labour"*
> public sector midwife in FGD 3

During an observation session in a central hospital's maternity ward, the researcher found that on average a child was born every fifteen minutes. There were two trained midwives at work. The word "stress" was not used by any of the Malawian midwives, however the following quote describes what could be categorised as work related stress (36):

> *"You will find that you have to work in the female ward and there is nobody to work in the paediatric ward and you also have to be in the ICU. And they expect you to give quality care. This is so frustrating. And do you expect this nurse/midwife to come to work tomorrow? She may fall sick and not be able to work"*
> public sector midwife in FGD 4

The working conditions in the private-for-profit sector were envied by the public sector midwives. However as a midwife with experience from both sectors put it:

> *"In the public all you do is to hand out drugs to the patients. In the private sector midwives do everything: Wash, mobilise, change dressings. There is no auxiliary staff to help with that, so you are equally busy"*
> private-for-profit sector midwife in interview

Lack of **equipment and supplies** contributed to the poor working conditions:

> *"There are not enough resources in the hospital: You will find that the drugs, cotton wool and sometimes even gloves are short supply… Sometimes things like those are why midwives do leave their job"* public sector midwife in FGD 2

> *"The main reason for midwives not wanting to go to that health centre and work is that there is no water and no electricity. They are now electrifying the health centre and believe that can attract staff. This has attracted staff in the past"*
> public sector manager in interview

Again, there was a difference between the public and private-for-profit sector:

> *"In the private sector you do not need to improvise. There is the equipment and supplies you need"*
> private-for-profit sector midwife in interview

The midwives expressed concern about the poor and not enabling working conditions at a time where midwives are increasingly held **accountable for mistakes**:

> *"Sometimes if a nurse makes mistakes which may cause someone to die, sometimes we do accept the responsibility for our mistakes. But sometimes our mistakes are there because of several things. You can imagine one nurse has to look for more then sixty patients, what would you give them? You can't give them total care. There are some other things that a nurse is expected to do as well, like supervising. And sometimes you just have to decide to do one important thing and the rest of the things just fall on your side. With that you are able to make mistakes"*
> public sector midwife in FGD 2

> *"We are lucky because most of our patients are illiterate and they don't sue us"*
> Public sector midwife in FGD 1

4.3.4 Human resources functions

In this section, the author will present quotes which can be categorised under the broader term, human resources functions. These are quotes on staffing levels, followed by quotes on rural postings. Next are findings on post-basic training and development and career structure. Finally, a manager's view on the challenge of managing.

Everyone interviewed for this study confirmed that there are **low staffing levels** in the maternity wards. Most interviewees said that half of the established posts are vacant. Yet, there is more to it than what numbers tell, as the following quotes illustrate:

> *"…you see once people go out of the system…the impact on those remaining is so great. You now feel the shortage more than you used to and* [as a consequence] *the ones remaining want to go too because it's just too much"*
> public sector midwife in FGD 4

> *"In health centres the pressure goes on a nurse, you find a nurse doing everything alone, she has to work as a medical assistant, midwife, and she works like that around the clock. She is also supposed to rest or do her own things like having a bath, prepare a meal for herself. She can be away doing that, and a patient comes and a maid helps her delivering. That is an issue because the maid is not trained to deliver still she will have to accept the responsibility. Even the headquarters know that nurses are running health centres by themselves and there is nothing which is being done about it. Now they have abandoned the medical assistants*[29]*, yet problems are still*

[29] Training of medical assistants was abandoned a while ago

coming. Who do they think is doing the job of the medical assistant? Nurses have to do it all by themselves. There is also a lot of political pressure, a health centre has been closed in my constituency, and the headquarters is saying it should be opened. Yet there is one nurse only"
public sector manager, trained as midwife, in FGD 2

"Those who leave are rarely replaced"
public sector manager in interview

The private-for-profit health sector experiences retention problems as well. However, the interviewed private-for-profit sector manager said that they did not have vacant posts despite high turn over. In other words, they manage to replace the leavers relatively quickly.

Posting of a female work force such as midwives in **remote rural areas** is problematic since:

"you cannot ask someone who is married to go and work in a rural place when her husband is in the city"
public sector manager in interview

"[unmarried women] say*' it is too far, who is going to marry me there?' "*
public sector manager, trained as midwife, in FGD 2

"Sometimes they post you where you do not want to go. At least they should ask you before posting you anywhere"
public sector midwife in FGD 3

If you force her [i.e. to work in a less attractive place] *she will negotiate with others* [other employers] *and you just see her coming to give you the keys and off she goes to her new job. So you remain stranded and there is nothing you can do but to close the health centre"*
public sector manager, trained as midwife, in FGD2

In order to fill a midwife position in a remote, rural health centre, Blantyre district has taken a new approach: Midwives are rotated between urban and rural health facilities and the system works.

The midwives felt that they had to wait for a long time to access **post-basic training and development**[30]:

"I worked for about 15 years before I came to school [school in the sense post-basic training] *some have worked for 10 years and even some have retired without going to school. That means it is a thing that you wait for but you are not really sure of when that will be"*
public sector midwife in FGD 3

The access to midwifery-training, i.e. basic training, is much debated in Malawi. The basic training has to do with production of staff rather than retention of staff, and thus it is beyond the scope of

[30] i.e. further training and development after having graduated as a midwife

this study. Nevertheless, the issue of basic training often came up during data collection and in those cases the researcher did not cut short the views to be expressed. A summary of these "patchy" findings are below.

In 2001, midwifery was taken out of the mandatory curriculum for nurse/midwives and was made optional.

> *"I regret the idea. We did not even know what the impact would be"*
> Senior official in MOHP in interview

> *"A nurse who has only been trained as a general nurse* [i.e. without midwifery] *can not work at a health centre, because at the health centre you need to have both nursing and midwifery… It will be more expensive for the government because they will need both a nurse and a midwife, which is usually not the case now"*
> public sector midwife in FGD 4

> *"The shortage of midwives is because we do not produce enough"*
> Senior official in MOHP in interview

As in the case of post-basic training and development, the midwives felt that they had to wait for a long time to be eligible for promotion: There was a perceived lack of **career structures.**

> *"The government should also consider creating career structure. It does not impress us the way they are doing it"*
> public sector midwife in FGD 3

There was a general feeling among managers in the MOHP that it is **difficult to manage** in the current situation:

> *"You are just given responsibility without resources and you have to make things work right. How can you do that? When gloves are in short supply how can I demand from a midwife to be hygienic in her work routines?"*
> public sector manager, trained as midwife, in FGD 2

4.3.5 Job satisfaction

In discussions with the midwives regarding job satisfaction**,** two themes came up, namely "quality of care" and "appreciation". These themes will be presented in this section.

The midwives felt that the working environment did not enable them to provide **quality of care** to the patients, and that was a reason for dissatisfaction:

> *"The environment we work in is not good. The resources are not enough and it's not comfortable for us when there are not enough resources. It's hard for us to do our work properly"*
> public sector midwife in FGD 3

"The patients can afford the drugs, so you can treat them with what should be given. That gives job satisfaction"
private-for-profit-sector midwife in interview

"All the midwives tell about the good old days. That the quality of care that they could provide back then was better"
interview with a manager in an NGO involved in maternal health

A few midwives made a link between quality of care and remuneration. However, it should be born in mind that these quotes were not typical, but outliers:

"This quality care thing will never be possible because people are focused on how they can get more money and not focused on their patients. Patient care is something secondary to a nurse/midwife in Malawi. The reason is that she has to feed herself first before she looks after the patient, otherwise she also becomes a patient"
public sector midwife in FGD 2

"I make more money on rearing chickens than on my salary… when I am at work I think of the chickens and I cannot concentrate"
public sector enrolled nurse/midwife in FGD 1

Lack of **appreciation** from officials, public and other cadres was repeatedly mentioned as a cause for dissatisfaction:

"The top officials should learn to speak positive about the nurse/midwives. Not only negative because it discourages us and leave us with the impression that we are never doing anything good"
public sector midwife in FGD 3

"By the end of the day, the general public does not appreciate what we are doing in the hospitals. Every time we are criticised. They don't understand the situation we are working in and because of that we are tired and fed up"
public sector midwife in FGD 3

"*Nurse/midwives do not get recognition... On paper the matron is the manager of the nurse/midwives, but in reality the doctor is ruling the wards. There should be recognition from other cadres"*
President of Association of Malawian Midwives in interview

The midwives feel that the lack of appreciation has been fuelled by policies such as:

"Low salaries and all that has led people to perceive the nursing profession… as low status… Like now they [the government] *has introduced the training of auxiliary nurses*[31] *… Personally I don't agree… because it will just make people think that nursing is a simple thing and that you can be a nurse in a few days…This thing will make other people look down on nursing. Yet people are spending years and years studying to be qualified nurses"* public sector midwife in FGD 4

[31] In a response to shortage of nurse/midwives, the MOHP recently launched a new cadre called "auxiliary nurses" which will be trained mainly on the job (67)

Discussion with midwives in the CHAM and the private-for-profit sector revealed a different picture:

> *"In the CHAMs, the nurses are respected.* [That is to say] *they work together and are close as a family. They help each other"*
> CHAM midwife in FGD 2

> *"The patients are demanding… at the same time they appreciate your effort"*
> private-for-profit sector midwife in interview

4.3.6 HIV/AIDS

This section will first quote midwives on the occupational exposure to HIV/AIDS as a factor affecting retention of midwives. Then the relative exposure between sectors will be touched on. Next the availability of preventive measures against HIV/AIDS in the maternity wards will be listed. Finally, findings from FGDs on the impact of free anti-retrovirals (ARVs) on retention will be presented.

The midwives said that the **exposure to HIV/AIDS** at work contributed to people leaving.

> *"Many people do not want to work in the labour ward because of the great exposure"*
> public sector midwife in FGD 2

There was no consensus, though, as to whether the risk was higher in the maternity ward than in other wards: Some felt the risk was higher while some felt it was the same.

One focus group mentioned that they perceived a **greater exposure to HIV/AIDS in the public than in the private-for-profit health sector:**

> *"There is much more exposure* [to HIV/AIDS] *in the public than the private. Mostly because the patients in the private are out patients and are not admitted. While in the government hospitals they are admitted"*
> Public sector midwife in FGD 2

There was a general feeling that the employer did nothing about the occupational hazard the midwives are exposed to:

> *"If a nurse/midwife get sick because of the hospital conditions, nothing is being done and they will say that it is her own fault"*
> public sector midwife in FGD 2

> *"Midwives feel that no one cares about their risk of getting HIV/AIDS"*
> interview with a manager in an NGO involved in maternal health

More specifically, there was no **risk allowance** and no **health insurance**:

"There are many diseases we are exposed to, but we don't have risking allowances. When we get sick there is no compensation for that risk"
public sector midwife in FGD 1

"Allowances should also be included such as health insurance"
public sector midwife in FGD 3

Neither was there access to **post exposure prophylaxis**[32] (PEP) except in the case of the one private-for-profit midwife studied:

"If you have a needle injury, the full procedure is followed and you are offered PEP for three months" private-for-profit sector midwife in interview

Gloves were not always available, except in the private sector case:

"Most of the time we do have gloves in the maternity ward"
public sector midwife in FGD 4

"*Sometimes we order them* [gloves] *and we are told there is no supply"*
public sector manager, trained as midwife, in FGD 2

"We always have gloves"
private-for-profit sector midwife in interview

During collection of primary data, i.e. FGDs, interviews and observation session, no employer was found to offer **ARVs** to the employees. However through secondary data, it was found that Médecins Sans Frontières (MSF) in Thyolo District provides free ARVs to all district health staff who need it (8).

The likely **impact of free ARVs on retention** of health staff turned out to be the most unexpected and surprising finding of the study. The midwives in the FGDs expressed strong doubts about whether free ARVs would keep them in the job and they did not feel that free ARVs should be a priority:

"ARVs should not be a priority"
public sector midwife in FGD 4

In contrast to the midwives' perceptions, some key informants were supportive of the idea of free ARVs and believed that they would be well-received by the midwives:

"We thought they [public health workers] *would be jumping up and down"*
comment from health advisor in major donor agency

[32] PEP, post exposure prophylaxis, is a course of drugs to take after for example a needle injury to avoid catching HIV/AIDS

One senior policy maker gave the impression that it is a question of time before ARVs will be offered to MOHP staff:

> *"We have the budget for ARV for free to people working in the Ministry "*
> Senior official in MOHP in interview

It was unclear to the researcher whether the interviewee referred to employees in the Ministry of Health and Population in the capital or to all employees in the public health sector, including front line health staff in remote rural health centres such as midwives.

Everything the midwives said in focus group discussions relating to this topic is compiled in annex 13. In the discussion chapter, the author has reflected on whether FGDs were appropriate for probing into this sensitive issue. The author encourages those with a special interest in the impact of free ARVs on retention to read both annex 13 and the discussion on the chosen research method.

4.3.7 Pull factors to stay in the public sector

This section will present the four identified pull factors which made the midwives stay in the public health sector. First, post-basic training opportunities. Second, leave policy. Third, retirement package and finally job security.

The following quotes are what the midwives said regarding **post-basic training opportunities:**

> *"There are better opportunities to get scholarships for studies in the public sector than in other sectors. Because of that some nurses still stay to get a masters degree"*
> public sector midwife in FGD 2

> *"The other thing why people stay is that in the government there is a chance of going back to school if you want… although it is not automatic that you can go to school. Sometimes you might not have a chance* [but then] *you can also go for minor trainings like this one*[33]*"* public sector midwife in FGD 3

> *"The good thing about the government is that they are interested in staff development. So those people who are interested to go back to school stay in the government waiting for a chance to upgrade themselves. That is basically the main reason* [why people stay]*. This is unlike in the private sector where they are only interested in your output and not developing you"*
> public sector midwife in FGD 3

One midwife interviewed from the private-for-profit sector answered promptly "training" when asked what could make her return to the public sector:

> *"I somewhat regret having left the public sector. I envy the people I graduated with who are now doing postgraduate training. I would have to pay that myself and it is too expensive. They stayed in the public sector to go for training"*
> private-for-profit sector midwife in interview

[33] Two weeks training in life saving skills with SMP

However, the pull of post-basic training is a two-edged sword: One the one hand, the opportunity to upgrade might make midwives stay. On the other hand, once they have received the post-basic training, they might be more likely leave the public sector as the following quotes illustrate:

> *"I stay because I want to get high education, because I know it is not easy to survive out there without papers, and after that I am also thinking of leaving"*
> public sector midwife in FGD 2

One midwife pointed out that the gain from shifting from the public to the private sector was higher once she has been trained:

> *"Personally I attended interviews in other private sectors but then I found out that the conditions were not satisfactory to me as compared to the ones in the civil service. Now that I will become a professional* [finish post-basic training], *it is possible that the conditions in the prospective organisation* [future employer] *may be much better than the ones in the public services"*
> public sector midwife in FGD 3

The **flexible leave policy** was a pull factor, since it helped the midwives combine professional and gender-generated roles:

> *"Even when there is a family member who is sick, you are given a chance to attend* [to] *that family member"*
> public sector midwife in FGD 3

> *"When they have small children, they can excuse themselves. While in the private sector they are so business oriented. If you are off, then money is deducted from your salary"*
> public sector manager in interview

> *"When a midwife marries or get a child she has problems doing night shifts. Her husband does not want her to. When the children are older, the night shifts are less of a problem"*
> private-for-profit-sector manager in interview

The **retirement package** was an important pull factor, especially among the older midwives:

> *"I have worked for a number of years and I am just waiting for my* [retirement] *package. After that I'll go for greener pastures***"**
> public sector midwife in FGD 2

One midwife described how her reasons for working in the public sector have changed over time, and what role the retirement package plays:

> *"I started in the public sector because I wanted to gain experience. Adding to that, in the old days, when I started working, there was not… a lot of NGOs… I am still in the public for my own development. I wanted a masters degree and thought I would get a better scholarship. That is why I decided to stay in the public. But in the long run I*

realized that I am nearing my retirement age, so I thought 'let me just hang on' until I get my package and after that I am considering to leave because the salaries are too low"
public sector midwife in FGD 2

The last pull factor identified was **job security.** The midwives felt secure in the public sector for two main reasons, namely the low risk for dismissal and the transferability:

On dismissal:

"As much as there are some things in the government which are not good, there are some things we do appreciate: There is job security.. I don't anticipate to be fired anytime"
public sector midwife in FGD 3
"[In the public sector] *when you have done something wrong they will simply transfer you to another hospital, but in CHAM they will fire you if they want to"*
CHAM midwife in FGD 4

On transferability:

"*Like in my case, I stay in the government because of my husband. His job makes him move a lot and if he goes to Mulanje, I will get a job, and if he moves to Chitipa I will get a job there as well. The government has got a hospital in every district and I can find a job there. Unlike in CHAMs, they don't have hospitals everywhere. Otherwise, without that, I would have left already by now"*
public sector midwife in FGD 4

"Where I am working most of the nurses are there because their husband works there or it's close to their home village"
public sector midwife in FGD 4

"Some of us are still staying really because we don't have much choice because of our families"
public sector midwife in FGD 3

4.3.8 AMAMI and MNMC

In addition to push and pull factors, another important theme arose during the data collection, namely the Association of Malawian Midwives (AMAMI) and the Malawi Nursing and Midwifery Council (MNMC). These findings are mentioned below. The **roles of AMAMI and MNMC**[34] were unclear to most midwives:

[34]AMAMI is the representative body or union, i.e. the voice of the midwives. It is meant to negotiate remuneration, working conditions etc. with the employer on behalf of the midwives (12). While MNMC is the regulating body and its role is to protect the public by overlooking midwifery in Malawi on behalf of the government. MNMC is involved in activities such as: development of the curriculum in the training institutions, registration of nurse/midwives and investigating cases of misconduct etc (68)

> *"AMAMI… this is just an association formed by nurses. We don't really know much about it. The only association which works is the council which is only active in punishing us and collecting contributions"*
> public sector midwife in FGD 4

> *"AMAMI? They have done some marches on Nurses' Day and also done some fund raising activities. That is what I know about them"*
> comment from senior employee in a project on maternal health

> *"We channel our grievances through AMAMI"*
> midwife and member of AMAMI in interview

There was a wish among the midwives to see a **strengthened union**:

> *"The other thing which is lacking in civil services is general meeting of all nurse/midwives… to be exposed to the experience of others and share what they go through. Together those in rural areas and in towns"*
> public sector midwife in FGD 3

AMAMI was launched in 1999 and has made substantial efforts to increase the proportion of Malawian midwives who are members, such as a nationwide tour to raise awareness on the union. However, they are not as established as they would like to be and currently one in ten of the Malawian midwives are members. AMAMI is increasingly recognised by the government who recently invited AMAMI to participate in a meeting on staffing issues. They have links with similar unions in other countries in the region, and are also member of the International Council of Midwives (ICM). The bottleneck in strengthening the association has been **lack of funds**, partly because the midwives cannot afford high membership. The President does not feel that donor funding would compromise their independence:

> *"What we do, the donors would agree to"*
> Ms. Lennie Kamwendo, President of Association of Malawian Midwives in interview

4.3.9 Summary of findings relating to objective two

This section has described the push and pull factors in midwifery as perceived by midwives and managers in the MOHP, CHAM and private-for-profit sector, with a focus on the public sector midwives' perceptions.

The main push factor was low salary. Other components in the **remuneration package**, such as housing allowance and retirement package were also felt to be unfair. Given the perceived inadequate remuneration, the midwives use a variety of coping strategies to make ends meet such as: accessing training allowances and emergency loans, run small businesses next to their job as midwives, sell food or pharmacy drugs to patients, doing shifts in the private health sector.

"Greener pastures" are a term often used by the midwives for destinations which are perceived as more attractive than where they are now. There was a "hierarchy of greener pastures", i.e. the least attractive place to work money-wise was the public sector. Followed by CHAM. Then the private-for-profit health sector. Next were NGOs. Finally, the greenest pasture in terms of remuneration

was abroad, either within the region or on other continents.

Under the heading of **"working conditions"** the following aspects were found to be push factors: The workload in the maternity wards is perceived as greater than in other wards. There is a lack of equipment and supplies and the midwives feel that they are occasionally held accountable for mistakes which happen because of the poor working conditions.

The midwives felt pushed out of midwifery due to poorly managed **human resources functions** resulting in low staffing levels, waiting for a long time to access post-basic training, and unclear career structures. The managers in the public sector felt that it was difficult to manage in the current situation and they found it problematic to fill midwife posts in rural remote areas with a largely female work force.

Lack of **job satisfaction** was another push factor. The midwives felt that they could not give the quality of care that they used to give in the past, and that officials, other health cadres and the public did not appreciate the care they gave.

The **HIV/AIDS** epidemic contributed to pushing the midwives out of the public sector as the exposure was perceived as greater there than in the private-for-profit health sector. The public health sector did not provide a risk allowance, health insurance, post exposure prophylaxis, or anti-retrovirals. Sometimes gloves were not available. A side finding to the study was that the impact of free ARVs on retention is unknown. However, this finding might be due to inappropriate research methods and thus it might not be a trustworthy finding, as discussed in the following chapter.

Pull factors to stay in midwifery in the public sector were found to be better post-basic training opportunities and a more flexible leave policy than outside the public sector. Moreover the midwives stayed waiting for the retirement package. Another pull factor was the job security, i.e. dismissals are rare and the midwives are guaranteed a job if they have to move in order to follow their husband.

During the data collection **AMAMI and MNMC**, i.e. the union and the council respectively, emerged as a theme. The midwives were confused about how the roles of AMAMI and MNMC differ. The midwives expressed a wish for a strengthened AMAMI and it was found that lack of funds is a barrier preventing AMAMI from growing stronger.

CHAPTER FIVE - DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The overall aim of this study was to identify factors affecting retention of midwives in Malawi. To achieve this aim, the study described the size of the retention problem among midwives and the main destinations for leavers. Moreover, the study described the managers' and midwives' perceptions of factors pushing the midwives out of the public health sector, as well as pull factors attracting the midwives to stay in the public health sector.

This chapter will discuss the findings of the study in the light of the reviewed literature and the context. The themes will be discussed in the following sequence: first, the extent of the retention problem, second, the identified push factors and the retention strategies which can counterbalance them. Third, the pull factors. Then, two emerging themes will be discussed, one being AMAMI and MNMC, the other being the basic training of midwives. Next is a section reflecting on the limitations of the study and appraising the study design and methods. This is followed by conclusions based on the findings. Finally, the researcher will make recommendations on improving midwifery retention.

5.2 The extent of the retention problem

The Millennium Development Goal (MDG) indicator is that eighty percent of births should be attended by a midwife, nurse or doctor with midwifery skills, i.e. a skilled attendant, in 2005 (1). About half of the deliveries in Malawi are not assisted by a skilled attendant (14).

Vacancy rates depend largely on the number of established posts, which is a subjective decision, and thus vacancy rates do not necessarily reflect the actual shortage of midwives (28,45). However, anecdotal evidence from midwives and managers support the finding of vacancy rates among midwives ranging from about twenty to fifty percent.

Staff shortages are dynamic and change over time. As a result, the size of the problem needs to be monitored on an on-going basis. A very useful contribution to this was the **MNMC's database** funded by USAID until December 2003. The database is to be handed over to the MOHP by the end of 2003 and the MNMC expressed doubts about the sustainability of the database in year 2004 and onwards.

While statistics could describe the extent of the retention problem, **exit interviews** are a management tool telling about the nature of the problem. The purpose of these interviews is to ask leavers about their perception of push-pull factors in the organisation and why they leave (23,34). It can be argued that this study is a sample of exit interviews, as it used the kind of information which is available to the employer through exit interviews. However, the findings are from midwives who often expressed intention to leave, rather than actual leavers.

5.3 Push factors and counterbalancing retention strategies

In this section, the author will compare the push factors found in the study with the push factors identified in the reviewed literature. The literature review suggested retention strategies to mitigate some of the push factors. For those push factors, the author will discuss the retention strategies alongside the push factor.

The main push factor identified by the study was an **unfair remuneration package.** Other push factors, such as lack of appreciation and opportunities for promotion, were less important. This finding is supported by Herzberg's and Maslow's theories which emphasise the importance of meeting the basic need for adequate remuneration before appealing to higher needs such as esteem and self fulfilment. **Delayed payment of remuneration** was identified as a push factor in both the literature and the study.

Against a backdrop of inadequate and irregular remuneration the midwives have developed **coping strategies** (40) to make ends meet, some of which impact negatively on the quality of care. **Post-basic training** was sometimes used as a coping strategy: The main purpose of post-basic training as a management tool is to develop employees (34). Post-basic training as a coping strategy is used to supplement inadequate income with training allowances, or to increase one's value in the labour market and possibly leave the job (40).

An obvious strategy for retaining midwives would be to **increase the remuneration package**. However it is difficult for the MOHP to do so for one cadre alone (45), and moreover it is difficult to see where the money could come from. External funding might be needed if the remuneration package is to be brought up to a realistic level to retain the midwives. This has been problematic for the donors in the past but new initiatives such as Sector Wide Approaches (SWAps) and Budget Support might give donors the opportunity to reconsider previous approaches (9)

One of the two main forms of losses of midwives was found to be loss to **"greener pastures"**, i.e. migration within the country, within the region or to industrialised countries. This was a significant loss, not only in quantity but also in quality, as it was the experienced midwives who were found to migrate. The study identified a variety of destinations for migrating midwives within Malawi, within the region and in industrialised countries. The reviewed literature mentioned **codes of practice, bonding and managed migration** as strategies to counterbalance loss of health workers to migration. Considering the severity of the shortage of midwives and the significant role which loss to migration play in this shortage, it is recommendable for stakeholders in Malawi and in major recipient countries to continue addressing the issue. In doing so they could consider the appropriateness of the above retention strategies for their specific context.

The **working conditions** were identified as a push factor. Herzberg's definition of working conditions (24) captures well the aspects highlighted by the midwives, namely a non-enabling environment and a high workload. The poor working conditions contributed to work related stress (36) among the Malawian midwives. Moreover the Malawian midwives, like the British midwives (21), felt threatened by the possibility of being held accountable for mistakes.

Career structures serve to develop and promote junior staff into senior positions to the benefit of both the organisation and the employee. Lack of a clear career structure was mentioned as a push factor in the literature reviewed (29) and also by the midwives.

Lack of job satisfaction was another push factor mentioned by the midwives. Herzberg found that in addition to the basic needs being met, it was also necessary to meet the "satisfiers" in order for the employee to feel job satisfaction. **"**Satisfiers" were for example recognition and a sense of achievement (24). This supports the findings in Malawi: the public sector midwives mentioned lack of recognition/appreciation as a cause for dissatisfaction with their job. Moreover they lacked a sense of achievement as they could not provide the quality of care they wanted to give, and were used to give. The private-for-profit and CHAM midwives gave the impression of being more satisfied in their job and this is a competitive advantage which does not favour the retention of midwives in the public sector. Therefore, it might be a priority to address the lack of job satisfaction among the public sector midwives, using the two retention strategies identified in the literature: namely the **Thai and the Indonesian initiative** which both aim at increasing public recognition and thereby improving job satisfaction.

The gender aspect was mentioned in the reviewed literature in relation to accepting **remote, rural positions** (32,38). The managers and midwives confirmed that it was a challenge to avoid urban-biased distribution of the midwives largely due to gender roles. **The Blantyre District strategy** of rotating midwives between urban and rural health facilities seems to have overcome the gender based barrier to accepting remote, rural positions. Possibly because the rural posting is temporary and/or because the monetary benefit is perceived as adequately compensating for the interruption in fulfilling domestic responsibilities. Moreover, this strategy has to some extent addressed the inadequate remuneration package by providing the midwives with an opportunity to supplement their income with the rural monetary incentive, while at the same time giving the employer the chance to address the urban-rural maldistribution of midwives (10).

5.4 Pull factors

The gender aspect also came through in two of the four pull factors identified by the study, namely in the pull of a flexible leave policy and job security.

Firstly, a **flexible leave policy** which enables the midwife to combine work-related and domestic responsibilities was an advantage in the public sector over the private-for-profit sector. This is in accordance with the reviewed literature which emphasised that gender relations impact on the distribution of a female work force. Both the study among Pakistani female health workers (19) and the study with British midwives (21) found that flexible leave policies could reduce loss of staff and may persuade those who have already left to consider returning.

Secondly, gender was an underlying reason why **job security** was an advantage in the public sector over CHAM and the private-for-profit sector. The midwives were expected to follow their husband if he moves for work, and the opportunity to transfer within the MOHP was thus much appreciated.

In accordance with the literature review, the **retirement package** was found to retain elder, but not younger, midwives in the public sector (34). One elderly midwife told how her reasons for working in the public sector had changed over the years and notably, the retirement package had first started

to play a role as a pull factor in the end of her professional life. Currently, the life expectancy at birth in Malawi is less than forty years (7) and many will therefore not reach retirement. This is likely to further weaken the pull of the retirement package among younger Malawian midwives.

It is not uncommon to find the same factor mentioned as push and pull, in studies using the push-pull framework (17,29). In other words, there is room for overlap between push and pull factors in this seemingly dichotomous framework. **Post-basic training** is one of those double-edged swords. In accordance with the literature, the midwives were reported to stay in the public sector to gain access to post-basic training, and also expressed intention to leave once they had finished this training (40). In contrast, post-basic training was found to be a pull factor which could make midwives return to the public sector. Therefore the potential for post-basic training to retain midwives and even make them return is important. It was beyond the scope of this research to review retention strategies specifically aiming at staff who had received post-basic training. Suffice to say that such retention strategies are available in the literature (34,69). Moreover, it is documented in the literature that post-basic training, in combination with adequate and well-imbedded retention strategies, may retain staff (34).

5.5 Emerging themes

In addition to push and pull factors, two other important themes arose during the collection of data. One being AMAMI and MNMC, the other being the basic training to become a midwife. They will be discussed in this section.

The reviewed literature suggested that it was good management practice to monitor information from employees via their representative body (45), and a midwife who was member of **AMAMI** said that she channelled her grievances through the union. The study also found that AMAMI was increasingly recognised and consulted by the MOHP, and the researcher found this to be a positive development which could enhance a joint approach to addressing the retention problem. It thus seemed a missed opportunity that lack of funds was a major obstacle for AMAMI's activities, and even more so because the midwives expressed the wish for a strengthened representative body. AMAMI reported that they would welcome donor funding, and the researcher found that the donors could consider this an activity aiming at strengthening civil society.

The literature mentioned that the roles of the representative body, i.e. AMAMI, and the regulating body, i.e. MNMC, were often confused by stakeholders. This was found to be the case in Malawi where the midwives did not appreciate MNMC fulfilling its role of investigating misconduct (68) but they frequently ascribed this activity to AMAMI. This could be a barrier for AMAMI in its effort to increase the proportion of Malawian midwives who are members, and thereby become more representative.

Basic training, i.e. training to become a midwife, was not within the scope of this study as it has to do with production/supply of staff rather than retention of already trained and employed staff. However, basic training often came up as a theme during data collection and it will therefore be briefly discussed here.

Until 2001 all registered nurses were also trained as midwives:

> *"Historically, the basic nurse training programme in Malawi was a three-year course which included midwifery. In 2001, the curriculum was changed to a two-year programme with nurse midwifery becoming an option for onward career advancement"*
> (64) page 11

It might have contributed to the shortage of midwives that nurses could now choose whether to attend midwifery training or not. However, resuming mandatory training of midwifery skills to all registered nurses will not solve the shortage of midwives if the retention problem is not addressed at the same time, i.e. "the leak is sealed" as the following quote says:

> "*Expanding training capacity* [i.e. basic training]*… has often been the main and immediate response to…* [shortage of health workers]. *Expanding production without sealing the leak cannot be an efficient response"*
> (27) page 7

The researcher therefore found it unfortunate that a senior official in the MOHP expressed that "*the shortage of midwives is because we do not produce enough"* and that this interviewee did not associate the shortage of midwives with the "unsealed leak".

5.6 Reflections on limitations, design and methods of the study

The section begins with a description of the limitations of the study. This is followed by a reflection on the study design and research methods, and how these might have affected the quality of the data. It is hoped that these reflections will be useful for eventual, similar studies in the future.

The **limitations** to the study were as follows: first, it was a limitation that data could not be collected from midwives who had left midwifery. The initial idea of snowball sampling (55) these leavers was unsuccessful. However, the midwives who participated in the study frequently expressed intention to leave, and so their perception of why midwives leave the job is taken as a proxy for reasons why those who actually left, did so. Second, the MNMC database could only be accessed once. Despite continuous efforts the researcher did not manage to get in contact with the IT consultant maintaining the database a second time. Consequently, the analysis of "relative importance of leavers' destinations" is based on a smaller group of midwives than the researcher had wished for. Third, lack of transport and pending permission limited the researcher from doing an observation session in a rural health centre in order to triangulate with findings from an urban maternity ward. Therefore the findings from the urban maternity ward are hardly used in the dissertation. The rural viewpoint was ensured in verbal data from rural-based midwives participating in FGDs. Another limitation was that payrolls and salary scales were considered too sensitive to share with an outsider and therefore the remuneration package could not be described in actual figures, but was instead described through the quotes on how the midwives perceive the package. Finally, it was a limitation of the study that in-depth interviews could not be conducted with midwives known to live with HIV/AIDS. This was due to ethical concerns about a masters student collecting such sensitive data over a limited period of time.

This last limitation influenced the **study design**, and affected the quality of data, as will be described in the following.

Death, largely due to **HIV/AIDS,** was one of the two main forms of losses of midwives. At the same time, the midwives perceived exposure to HIV/AIDS as greater in the public sector than in the private-for-profit sector. Literature suggested that exposure to HIV/AIDS was perceived as greater in obstetrics (and surgery) than in other wards (39). This was not confirmed by the Malawian midwives, however. In short, exposure to HIV/AIDS was a push factor which significantly affected retention of midwives in the public sector.

This calls for retention strategies protecting the midwives from exposure to HIV/AIDS at work and also prolonging the (work) lives of those infected. While there is an extensive body of literature on prevention of HIV/AIDS in the work place (70,71,72) the literature review identified little existing knowledge on the likely impact of **free ARVs** as a strategy to retain staff. The two pilot projects identified in the literature both described a low uptake of free ARVs largely due to denial (8,48).
This study found that the midwives, in contrast to a policy maker and a donor representative, did not see free ARVs as a priority. However, sensitive issues are often not well explored in FGDs (54): If an FGD participant acknowledges the value of free ARVs, then this could be perceived by the other participants as an indication that she is HIV positive. The FGD-midwives' dismissal of free ARVs might therefore not be a trustworthy finding but a finding resulting from inappropriate research methods.

The trustworthiness of the FGD-finding could have been further tested in interviews. It can be argued that these in-depth interviews should be conducted with midwives known to live with HIV/AIDS for reasons explained in the following. In-depth interviews with midwives not known to live with HIV/AIDS would not shed much light over the issue: due to denial, these midwives may not consider themselves at risk and they are therefore not very likely to perceive free ARVs as of value to them. In other words, midwives who recognise that they are infected and who are open about it in an in-depth interview, are more likely to reveal what the uptake of free ARVs would be, and thus the likely impact on retention. However, such in-depth interviews could not be conducted within the limits of this study.

The chosen qualitative **research methods**, i.e. in-depth interviews, FGDs, observation session and presentation meetings were found useful to achieve the aim of the study. The researcher regrets that in one FGD, a midwife working as a manager in the public sector participated alongside public sector midwives. When the researcher realised this, it was too late to change. The manager's presence might have made other participants feel less free to speak.

The researcher is a European nurse and this might have biased the findings by bringing out the issue of migration to the industrialised countries more in the interviews and the FGDs.

5.7 Conclusions

This study found that Malawi is not on target in achieving the Millennium Development Goal on maternal health. There are various ways of measuring the poor retention of midwives and these ways have inherent ambiguities. However, regardless of how the poor retention is measured and what the ambiguities might be, it seems that there is a severe and longstanding problem with retaining midwives.

Continued close monitoring of the problem forms a basis for addressing the retention problem. MNMC's database was found useful for monitoring, but the sustainability of the database is questioned. Exit interviews were also found of use in monitoring the problem.

This study identified the inadequate remuneration package as the main push factor. The midwives were found to use multiple coping strategies to supplement the remuneration package. On the one hand these coping strategies enable them to stay in the public sector. On the other hand, there are often negative consequences on the quality of care from coping strategies. Implementation of a set of retention strategies which appeals to the midwives' higher needs without addressing the remuneration issue is not likely to have significant and sustainable impact on retention. The Blantyre initiative of urban-rural rotation of midwives addresses this issue to the benefit of both the midwives and the employer.

Loss of midwives to migration was found to contribute significantly to the shortage. Possible ways of mitigating this loss could be to continue current efforts in enforcing codes of practice in recipient countries. This could go hand in hand with continued efforts in making the public health sector more attractive to the midwives.

Poor working conditions, lack of career structure and lack of job satisfaction were also found to contribute to poor retention. Job satisfaction could be increased through media campaigns and public recognition awards. This would be a cheap, easy and feasible activity. As an added value, AMAMI could raise its profile by taking this task on board.

Against the backdrop of multiple strong push factors, the study found four pull factors, namely post-basic training opportunities, a flexible leave policy, the retirement package and job security. It might therefore be advisable to uphold and possibly build on these pull factors in future policy making within the field of midwifery.

There seems to an understanding among several stakeholders that the shortage of midwives could be solved if basic training of midwives was resumed. This is not supported by the reviewed literature which emphasised the importance of also "sealing the leak" i.e. addressing the retention problem.

The study found that the midwives were confused about the roles of AMAMI and MNMC, and this could be a barrier for AMAMI in its efforts to become more representative. The midwives expressed a wish for a stronger AMAMI and at the same time a strengthened union could facilitate communication between the midwives and their employer, the MOHP. This could enhance a joint approach to addressing the retention problem and it might therefore be advisable for donors to consider funding AMAMI as a civil society activity.

The study did not generate trustworthy findings on the likely impact of free ARVs on retention of midwives in Malawi. The research methods, i.e. FGDs, were inappropriate to explore this sensitive topic, and a more appropriate method, i.e. in-depth interviews with midwives living with HIV/AIDS, was not available to this study. Therefore the likely impact of free ARVs on retention of midwives in Malawi remains unknown. Eventual further research on the topic might consider in-depth interviews with midwives living with HIV/AIDS.

5.8 Recommendations on improving retention of midwives in Malawi

The following recommendations are based on the above discussion and thus supported by the literature. Moreover, the recommendations are refined according to the feedback given by stakeholders at the two presentation meetings in Malawi. The researcher hopes that the recommendations will be useful to the task force that came out of the presentation meeting in Lilongwe and whose purpose is to look at ways of increasing skilled attendance in Malawi.

1. The donors might consider continuing the funding of the MNMC database, when the current USAID funding finishes by the end of 2003.

2. The human resources units in the MOHP could consider implementing exit interviews or commission them out. The long term goal could be to conduct interviews with all leavers. In the short term it might be more feasible to do occasional surveys following up small samples of leavers. Donors could consider funding such periodic retention surveys.

3. The task force could facilitate the identification of a realistic level for the remuneration package to retain midwives. This increment could be costed by the MOHP and/or the upcoming Health Service Commission, and discussed with the Ministry of Finance and/or donors under SWAps or Budget Support. However, there may be risks involved with the sustainability of donor funding of remuneration, and also risks with implications for remuneration of other staff in the public sector.

4. Other districts could consider the scheme of urban-rural rotation of midwives which is done successfully in Blantyre District.

5. DFID and development agencies of other countries that employ Malawian midwives could continue advocating for enforcement of codes of practice in their home countries. This could go hand in hand with the MOHP to consider ways of making the public health sector in Malawi more attractive for midwives. These recommendations and the dissertation as such might give ideas to how this could be done.

6. AMAMI and MNMC would benefit from scaling up current efforts in clarifying their roles to the midwives. AMAMI could consider increasing the midwives' job satisfaction by media campaigns as was done in Indonesia, and by public recognition awards as was done in Thailand. AMAMI would gain from increasing the proportion of Malawian midwives who are members, and thus become more representative. Donors could consider funding and thus strengthening AMAMI. This could improve communication between MOHP and the midwives and is thus likely to enhance a joint approach to addressing the retention problem.

7. There is a need for further research on the impact of free ARVs on retention of midwives. This research could benefit from conducting in-depth interviews with midwives living with HIV/AIDS. Experiences could be drawn from MSF-Luxembourg in Thyolo District in Malawi, from Anglo Coal in South Africa, and possibly from other pilot projects in the region.

These recommendations form a set of options available to the task force and other stakeholders. Each recommendation could be implemented independently of the other recommendations, so there is no logical time sequence for implementing the recommendations. Nevertheless, the researcher suggests that the third recommendation is seen as a first priority, since inadequate remuneration was found to be the single most important reason why midwives left. Moreover, if the inadequate remuneration is not addressed, then other retention strategies which appeal to the midwives' higher needs (such as job satisfaction) are unlikely to be successful, as discussed earlier. The second priority could be to consider recommendations five and seven. The reasons for this are that these recommendations suggest ways of mitigating the two major forms of losses, namely attrition to migration and to HIV/AIDS.

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Annex 1: Terms of reference (TOR) for the study

Title: A study analysing factors affecting staff recruitment and retention (motivation, incentives etc.)

Client: Martha Bokosi/ Hannah Ashwood-Smith, Safe Motherhood Programme

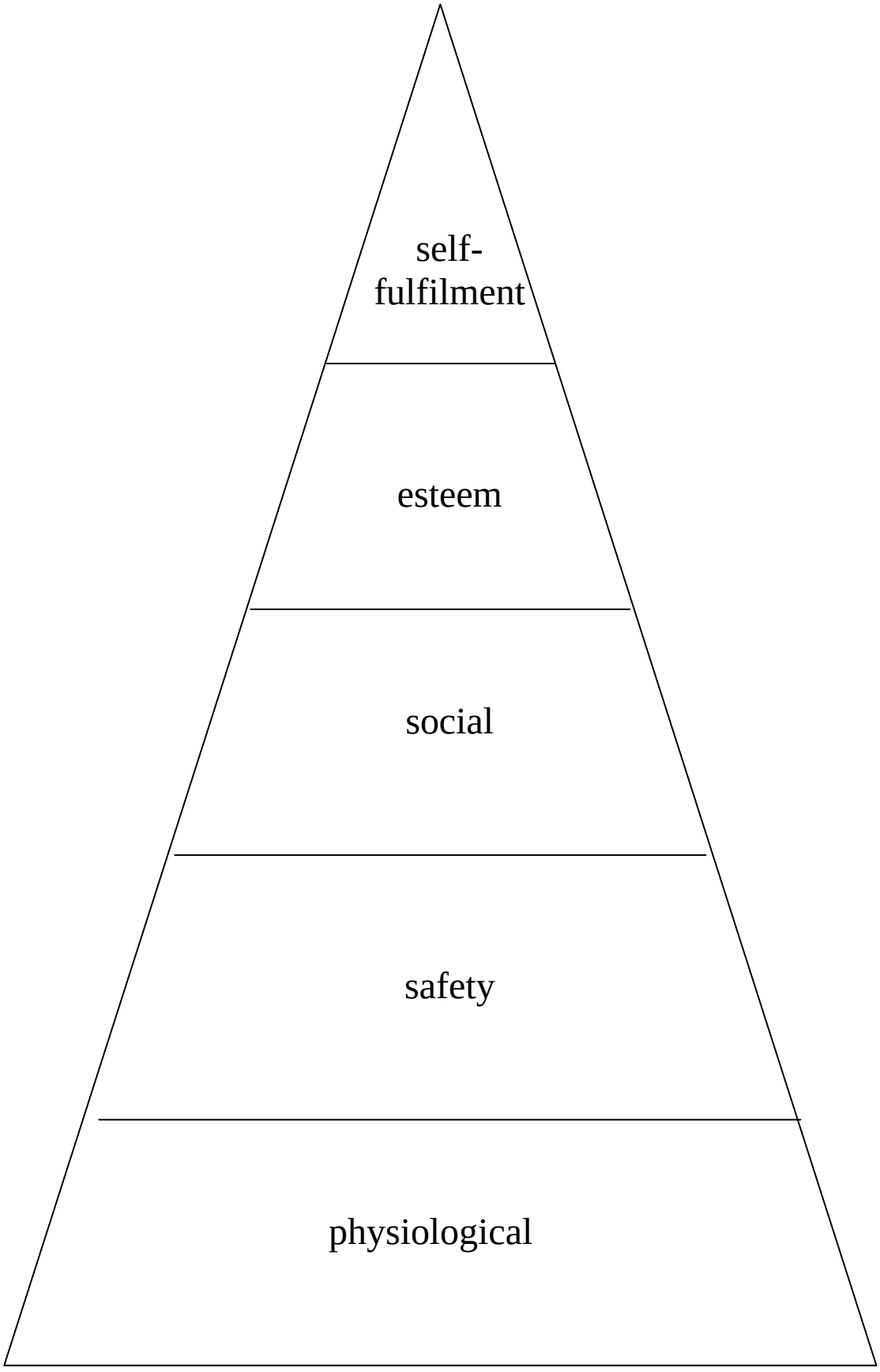
Location: Blantyre, Malawi

Further details:

Rationale: Critical staff shortages are renown in Malawi and contribute to poor quality of care in many fields, including maternal health. Several studies have been initiated to examine factors affecting staffing levels and recruitment but few have, to date, provided an in-depth look at motivational factors.

Research Question: What factors affect midwifery recruitment and retention?

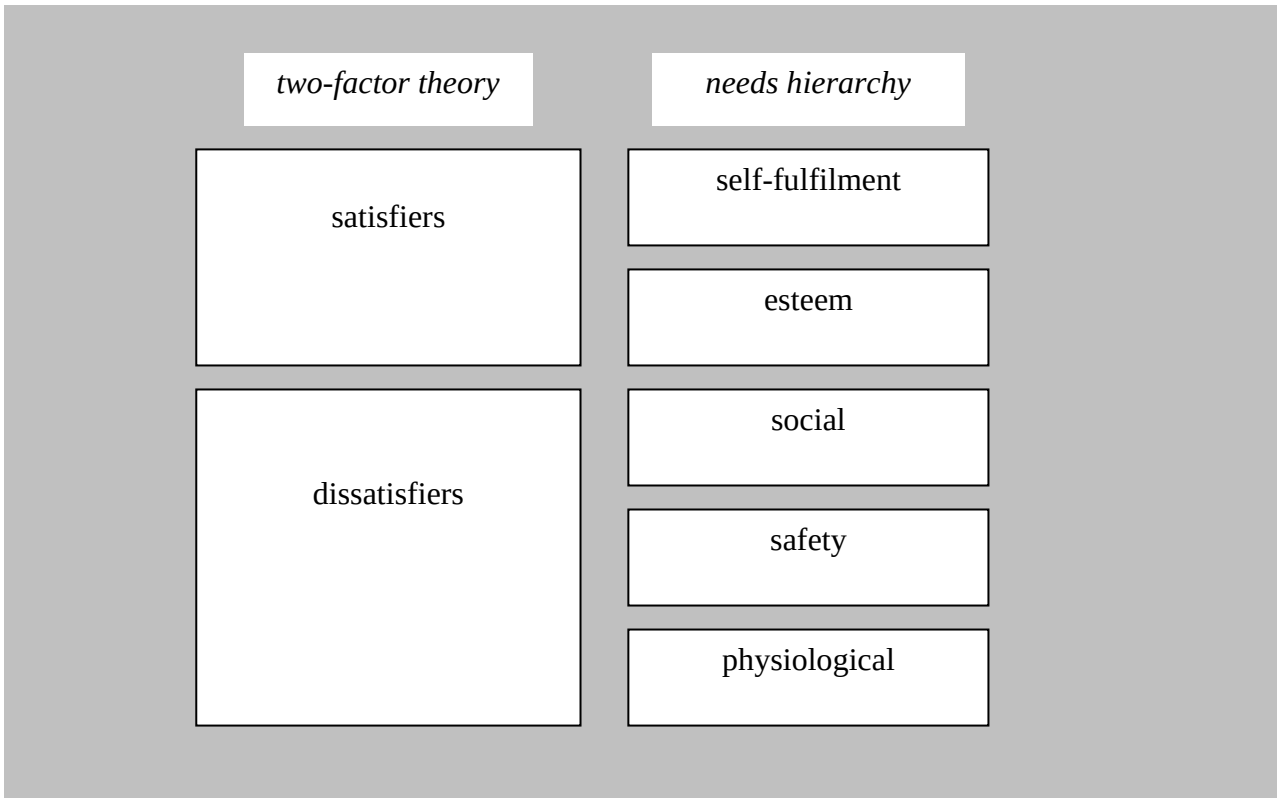
Annex 2: Maslow's needs hierarchy ***(source: title no 26 on the reference list)***



Annex 3: Herzberg's two-factor theory and Maslow's needs hierarchy

(source: title no 25 on the reference list)

Herzberg Maslow



Annex 4: Examples of codes of practice on international recruitment

Document	Statement
Code of Practice Department of Health England 1999 *(source: title no 50 on the reference list)*	2.11 It is essential that all National Health Service (NHS) employers ensure that they do not actively recruit from developing countries who are experiencing nursing shortages of their own. The only provisos to this policy are: •Nurses or midwives from these countries are seeking an opportunity for development, as part of a recognised programme which is approved by the relevant Governmental authorities in the country concerned. Or if NHS employers consider unsolicited applications for advertised posts directly from international recruits 2.12 In view of current nursing shortages abroad, recruitment from the Republic of South Africa or any Caribbean country should not be considered by a NHS employer, unless the aforementioned criteria (in paragraph 2.11) are met. Neither should employers contract nurses or midwives from these countries via private recruitment agencies
Code of Practice Department of Health England 2001 *(source: title no 51 on the reference list)*	Developing countries should not be targeted for recruitment of healthcare personnel unless the government of that country formally agrees via the Department of Health
Independent sector guide IHA/RNHA/VOICES 2001 *(source: title no 52 on the reference list)*	Independent sector employers will be aware of the sensitivities of targeting countries which cannot support large scale targeted nurse recruitment

Annex 5: Invitation for presentation meeting

August 2003

Invitation for a meeting regarding the findings of a survey
on the shortage of nurse/midwives in Malawi

Dear

The Safe Motherhood Project (South) initiated a survey looking at the shortage of nurse/midwives in Malawi. This survey has come to an end and we would therefore like to share our findings with you and other interested stakeholders at an informal meeting on

Friday the 12th of September 9 AM sharp until approximately 11 AM in the Conference Room of the DFID Health Office (in the building of the British High Commission, Lilongwe).

Unfortunately, we cannot reward your participation in this meeting neither can we reimburse eventual travel costs. However, we hope that you will be interested in joining us, as it will give you the opportunity to familiarize yourself with the findings of the midwifery retention survey. Likewise, the meeting will serve as a get-together of various people with an interest in the shortage of nurse/midwives. Your input during the discussion at this meeting will be very precious for us in order to further refine the recommendations identified during the survey.

Please let us know in advance whether you intend to attend this meeting at s@smp.malawi.net or via phone to 01 670 090.

Best wishes,

Esther Ratsma
Technical Advisor
Safe Motherhood Project (South), Malawi

and

Lene Ostergaard
Masters student
Liverpool School of Tropical Medicine, UK

Annex 6: Training of Malawian counterpart

Needs assessment:
The Malawian counterpart is a third year college student doing communication/journalism as her minor. She had lately done a short course with the World Bank in investigative journalism and she had very good interpersonal and communication skills. The Malawian counterpart had previous experience with translating for an international NGO and spoke English very well. She was not familiar with neither qualitative research or FGDs before this job, but she was eager to learn.

Plan for skills development:
Despite the Malawian counterpart being very qualified for the job, it was felt that it would be useful to ensure that she and the principal researcher had the same understanding of the following issues which were all relevant for the study:

- Ethics in research, including why informed consent
- The importance of privacy and confidentiality
- Qualitative research
- FGDs
- Challenges in translating
- Communication: open questions, probing, active listening, etc.
- Test skills in written translation of English-Chichewa
- Review topic guide together
- Practise tape recorder
- Mutual expectations: Time consciousness. Guide principal researcher if culturally inappropriate. Dress code.

It took in total two days to go over these points and it was done within the first two weeks, i.e. before the Malawian counterpart participated in any data collection. Throughout the eight weeks, the principal researcher and her Malawian counterpart further developed skills by mutual debriefings after each FGD.

Outcome:
The principal researcher and the Malawian counterpart worked well together and both enjoyed it and a recommendation letter was written for the Malawian counterpart. It was a great satisfaction for both the principal researcher and her Malawian counterpart that the latter was encouraged to contact DFID once she has finished her bachelor's degree, if she is interested in doing similar jobs in the future.

Annex 7: Check list and topic guide for FGDs

Seating (around the table)
Intro Grenna and I
Intro themselves
Drinks?
Brief intro of the survey
Questions to the survey?
Focus Group Discussion – what is that? (No right or wrong answers. Disagree is okay)
All enrolled or registered nurse/midwives?
Confidentiality (Grenna and I plus in-between group members)
Information and consent form pass around
Questions to form? Pls sign
Tape record (because can't remember by heart)
Take notes (in case tape breaks down)
(Grenna: Tape recorder is okay?)
Any questions?
Let's start!

- Why do midwives leave the job in Malawi?
  - pay
  - working conditions
  - housing
  - emergency loans
  - transport
  - equipment & supplies
  - quality of care
  - accountability
  - rural
  - training
  - promotion
  - appreciation
  - HIV/AIDS
  - Free ARVs – how do you feel about it? Could free ARVs make nurse/midwives stay in the job and/or get them back into work?

- What makes midwives stay in the public?
  - training
  - "excuse yourself" if relative is sick
  - retirement package
  - job security (transferability)

- CHAM as compared to public?
- Private as compared to public?

- How do you make ends meet?

- When midwives leave the job – where do they go?

- Have you heard about AMAMI, MNMC? How do you feel about them?

- What can be done to make midwives stay?

Summarise points raised
Anything else you want to share?
Thanking participants

Annex 8: Information and consent form for midwives

First of all we want you to know that we are happy to be with you here today. Thanks for welcoming us.

Who are we?
We are Grenna Kaiya and Lene Ostergaard. Grenna is a college student and helps Lene with translation. Lene is from Denmark and is a nurse of background. She has worked with staff issues for some years. She is now studying at the Liverpool School of Tropical Medicine in England. This research is part of her masters course there.

Why are we here?
Lene was invited by Martha Bokosi and Hannah Ashwood-Smith from the Safe Motherhood Programme to look at factors affecting retention of midwives in Malawi. In other words: Why do midwives leave the job?
In order to answer that question we would like to talk to managers in the health sector, midwives and nurses.

How will it be done?
We will sit down in a quiet and private place. If you allow, we would like to tape record and take notes of what is being said because it is impossible for us to remember every word by heart. Once we have written down what was on the tape, this will be erased and it will be impossible to know who said what.

A few words about participation:
We want to emphasise that it is up to you whether you want to participate in this study or not. Likewise if you agree to participate and there are questions that you feel uncomfortable with, then you are free not to answer them. If you want to withdraw at any time during the interview, you are also free to do so. This will have no negative consequences for you in any way.
At the same time, we want to stress that your contribution to this research is very precious. It is a chance for you to have a voice on how midwifery could become a more attractive job in Malawi. And no one knows that better than you.
Unfortunately, we cannot reward your participation.

Are there any questions?

Are you willing to talk to us?

Can we tape record and take notes?

I have read the above text and I consent to participate in the study (please sign):

Annex 9: Ethical approval from Research Ethics Committee at LSTM

LIVERPOOL
SCHOOL OF
TROPICAL
MEDICINE (Affiliated to the University of Liverpool)

Pembroke Place
Liverpool L3 5QA
Telephone: 0151-708 9393
Fax: 0151-705 3370
http://www.liv.ac.uk/lstm/lstm.html

14 July 2003

Ms Lene Skov Ostergaard
C/o Mr T Martineau

Dear Ms Ostergaard

The research protocol **A study identifying factors affecting midwifery retention in Malawi** Reference No **03.38** was considered by the Research Ethics Committee on **3 July 2003.**

Thank you for e-mail of 13 July 2003 with the information requested by the committee. The protocol now has formal Ethical Approval from the LSTM Research Ethics Committee.

This approval should not be seen as a substitute for Local Ethical Approval from the country/institution where the research is to be carried out and that you have undertaken to seek such approval wherever an appropriate mechanism is in place.

The Research Office (RO) maintains a Database of Local Research Committees in the countries where collaborative work is being carried out. Could you, therefore, feed back to me (via Sharda Mistry in the RO) as much information as possible on the local Committees/Review Bodies that will review (or have reviewed) this protocol. The following details would be much appreciated:

- Name
- Address
- Contact numbers or individuals (tel / fax / e-mail)
- A copy of the appropriate form or some details on the submission mechanism
- Any details you are able to obtain on
  a) number on the committee
  b) how many lay representatives sit on the committee?

Yours sincerely

Dr D Lalloo
Chair, Research Ethics Committee

Liverpool School of Tropical Medicine
An international centre of excellence in the field of tropical medicine and tropical health systems
A Company Limited by Guarantee
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Registered Charity No 222695

Annex 10: Ethical approval from Kamuzu College of Nursing

University of Malawi
KAMUZU COLLEGE OF NURSING

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING
12 -08- 2003
PRINCIPAL'S OFFICE
PRIVATE BAG 1
LILONGWE, MALAWI

TO : The Principal

FROM : Dean of Postgraduate Studies and Research

DATE : 12th August 2003 **REF. No.** KCN/DPGRS/1/4

RE : **UTILIZATION OF BSC MIDWIFERY STUDENTS AS RESEARCH SUBJECTS FOR LENE OSTERGAARD. "A STUDY IDENTIFYING FACTORS AFFECTING MIDWIFERY RETENTION IN MALAWI"**

I have reviewed the proposal for Ms Ostergaard a Masters' student studying at Liverpool School of Tropical Medicine on the above referenced study and her intention to include our students (BSc) as study subjects. I have mainly focused on the Ethics aspects of the study in as far as our students are concerned.

There are no major ethical issues pertaining to utilization of our students for as long as they do not feel pressured to participate because their program is supported by Safemotherhood and the researcher has also come to us through Safemotherhood.

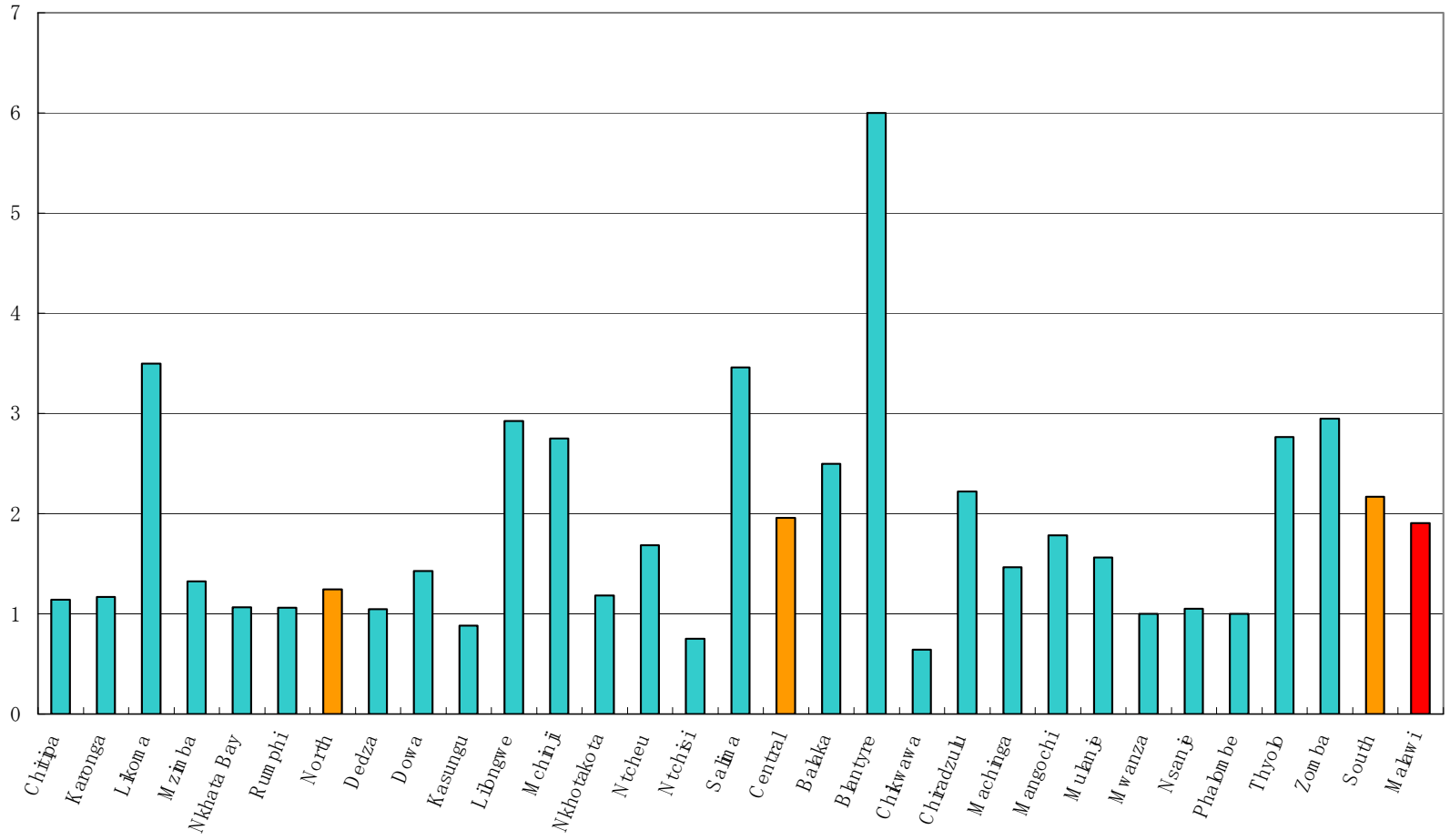
I propose that the students be informed that nothing will affect their future relations with Safemotherhood should some of them decline to participate. Besides this, I see no objection to her request.

C.P.N. Kaponda, Ph.D, MRNM
DEAN OF POSTGRADUATE RESEARCH AND STUDIES

CC : Dean of Faculty
Head of Department, MCH

cc: Safe Motherhood Project - BT office
Please pass this message to Ms Ostergaard.
CNkhoma
13/08/2003

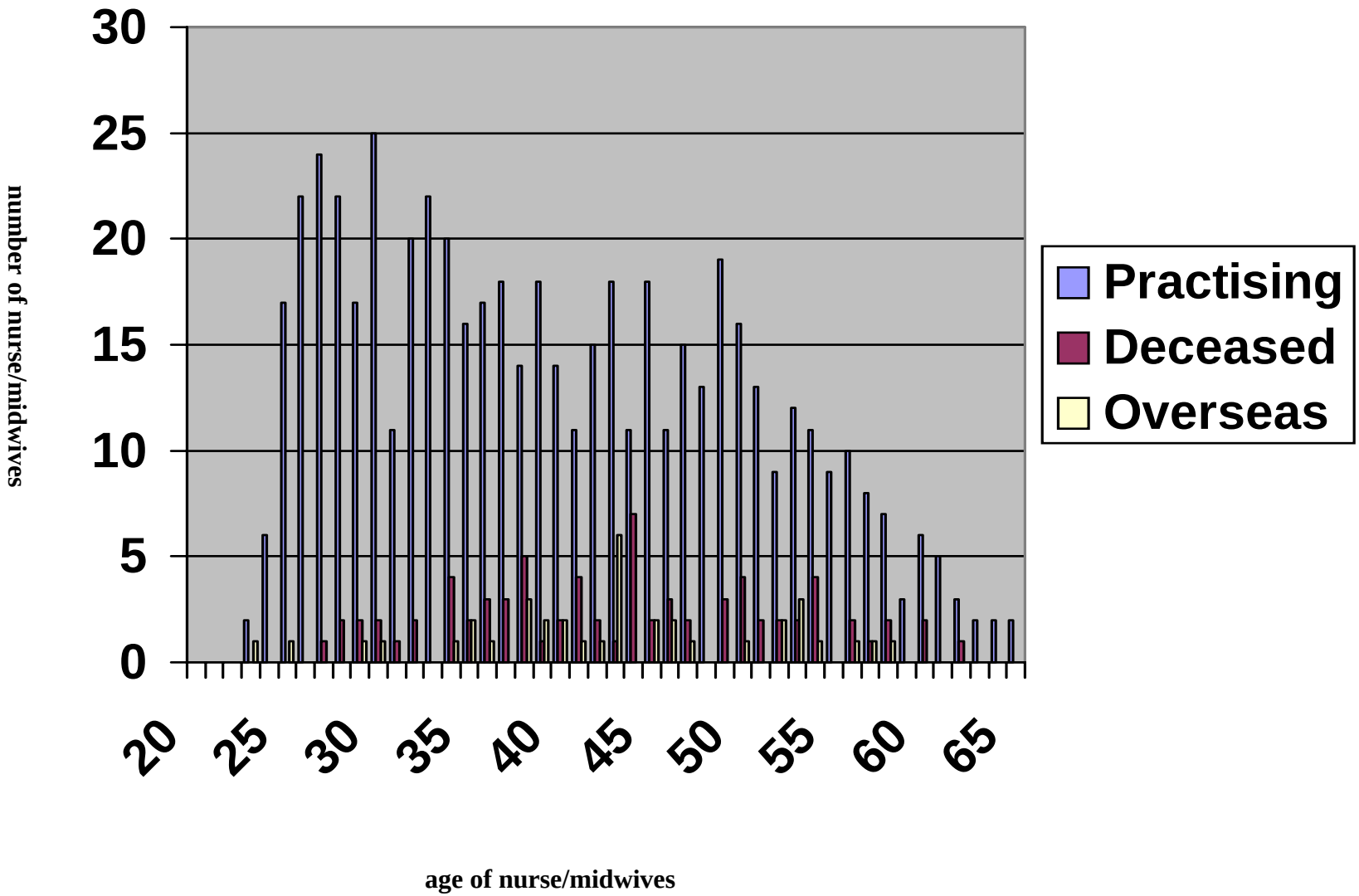
Annex 11: Number of midwives per health centre



Average number of nurse/midwives per health centre (MOHP and CHAM) by districts (blue) and by regions (orange) and nationally (red) *(source: title no. 65 on the reference list)*

Annex 12: Critical point(s) for leaving

(source:MNMC's database, n = 668)



Annex 13: Quotes on the impact of free ARVs on retention

This is a list of all quotes on the impact of free ARVs on retention of health staff as expressed by midwives during FGDs. Plus selected quotes from key informants:

- *"*[If the government gave free ARVs] *then those who are sick would come back* [into the public sector] *because they will know that there are services being provided, they will be given free drugs. At the same time, the ARVs would not make a nurse who is well stay: I mean, if you are not sick and you haven't started developing any signs for AIDS, then to appreciate the provision of ARVs would be a minimal thing. What these other people are looking for* [the midwives leaving the public sector] *is something which can make them live a comfortable life, and the thing which would make people stay is increasing of salaries. It is the people who feel healthy who go for work outside the government"*
  public sector midwife in FGD 3

- A manager from the private-for-profit sector said that they do not ask applicants for HIV-tests since that would be against the law. Instead they *"look for if the person looks healthy"*

- *"Free ARVs might help by keeping midwives in the public sector, but it would not have a great impact. Some would stay. It was demanded on the nurses' day for protection of nurses"*
  public sector midwife in FGD 2

- *"They should not only think of giving free ARVs. They should also think of salaries. They think we are HIV positive: Where have they taken it from?"*
  public sector midwife in FGD 4

- *"Actually for someone to take that drug you need nutritious diet and we don't have enough money to buy nutritious diet"*
  public sector midwife in FGD 4

- *"For example for someone like this one* [pointing at the oldest midwife among the participants] *she has worked for 32 years and she is HIV-negative. How can that* [free ARVs] *be important to her? It is unfair. ARVs should not be a priority"*
  public sector midwife in FGD 4

- *"Even if they give us ARVs freely, without money nothing can change and people would still not come. Most of us have extended families and our salaries do not meet our needs. If ARVs are given to the midwives then what about the extended family who might need the drug as well?"*
  public sector midwife in FGD 1

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Annex 13 continued: Quotes on the impact of free ARVs on retention

- *"Even nowadays with the HIV transmission there is nothing given to nurses despite the risk they take: Money is not there not even the anti-retroviral drugs. No risk allowances, so that also contributes to why midwives leave their jobs"*
  public sector midwife in FGD 4

- *"Another thing that I have noticed is that it's not ARVs only. In other countries like UK all the nurses are given the vaccination against diseases like tuberculosis and hepatitis B. But we never have any of those. We just work and in the end we catch the diseases"*
  public sector midwife in FGD 4

- *"We have the budget for ARV for free to people working in the ministry… it is mainly urban health staff who suffer from HIV/AIDS"*
  Senior official in MOHP in interview

- *"We thought they* [health workers] *would be jumping up and down"*
  comment from health advisor in major donor agency

- During an observation session in a maternity ward in a central hospital, the researcher saw a poster on needle injury which said*: "Some institutions may provide HIV/AIDS treatment. If so, start it immediately"*